PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559		LDING	NSTRUCTION 00	СОМ	e survey pleted 13/2013
	ROVIDER OR SUPPLIER			2901 B	ADDRESS, CITY, STATE, ZIP EVERLY DR IN 46408	CODE	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	111 40400		(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION)		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
W000000							
	recertification ar to a full survey (Healthcare Servi Body).	: 001073 er: 15G559	Wo	00000			
	These deficienci findings in according	QIDP IDP (4/15/13 to 4/19/13) es also reflect state rdance with 460 IAC 9. completed 5/10/13 by					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001073

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/03/2013		
	PROVIDER OR SUPPLIER			2901 BI	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W000102	The facility must a governing body a requirements are Based on observer record review, that to meet the Cond Governing Body clients (#1 and # clients (#3 and # failed to ensure on needs were not in health care service of clients #1, #2, governing body facility allowed of participate in confensure client #3's of the client's saw client's inability. The governing befacility reported abuse/neglect to to state officials ensure the facility measures regarding left for client. Based on interving governing body home maintained as related to Medical services are leased to Medical services.	met. ation, interview and be governing body failed lition of Participation: for 2 of 2 sampled 2) and for 2 additional 4). The governing body client #3's heath care eglected and the facility's ces met the nursing needs #3 and #4. The failed to ensure the clients #1 and #2 to munity outings, to a guardian was informed vings account, and of the to access her own funds. ody failed to ensure the all allegations of the administrator and/or for client #3, and to y put in place corrective ing an allegation of	W0	00102	The facilities procedure for handling consumers' funds w modified by 5/31/13 please st W 140. The facilities method assessing and developing pla following changes in client condition will be modified by 5/31/13 please see please se 331, W342, and W 369	ee of ins	05/31/2013

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G559	A. BUII B. WIN	LDING G		05/03/	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	KEGGE/TTOKT OK	ESC IDENTIFIEND IN ORDER TOOL		1710	·		DATE
	Findings include	:					
	1. The governir	ng body failed to meet the					
	Condition of Par	ticipation: Client					
	Protections for 2	of 2 sampled clients (#1					
	and #2) and for 2	2 additional clients (#3					
		verning body failed to					
	•	en policy and procedures					
		et of client #3 in regard to					
		cal needs. The governing					
	_	sure clients #1 and #2					
		utings/activities in the					
	•	nsure the facility kept a					
	•	ting of client #1, #2, #3					
		informed client #3's					
	_	elient's saving account, to					
		ions of abuse/neglect to					
		and/or to other officials					
	*	client #3. The governing					
	body failed to en	sure corrective measures					
	• •	e to address issues found					
	during an investi	gation of neglect to					
	prevent recurren	ce for client #3. Please					
	see W122.						
	2 The	a hadre failed to t the					
	_	g body failed to meet the					
		ticipation: Health Care					
		2 sampled clients (#1					
	· ·	2 additional clients (#3					
	· ·	cility's nursing services					
		e health care needs of the					
		The facility's health care					
	services failed to	assess, monitor and/or					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 05/03	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	failed to ensure for to meet the healt #3. The facility's failed to ensure a administered with The facility's heat ensure the facility times of medicate reviewed by clied doctors. Please so the group home of the governing by facility implement and procedures the client #3 in regard pneumonia and for the governing by facility allowed of the governing by facility kept a conclients' finances were not availaby #1, #2, #3 and #4 failed to ensure the client #3's guard	g body failed to ensure maintained medical s related to Medication Records for Client #2. ody failed to ensure the nted its written policies o prevent neglect of rd to aspiration						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 03/2013		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
	by the facility, as client's guardian access her funds account as the cl required credent	nd/or to inform the client #3 was not able to in the local savings ient did not have the ials/paper work.						
	facility immedia allegation of pos administrator im report an allegat Division of Disa Rehabilitative So (Bureau of Deve Services) per 46 Adult Protective 12-10-3 for clier failed to ensure tappropriate corre- provided retraini	sible neglect to the mediately and/or failed to ion of neglect to the bility, Aging and ervices (DDARS)/BDDS lopmental Disabilities 0 IAC 9-3-1 (b) (5) and to Services (APS) per IC at #3. The governing body						
	facility's Health nursing needs of governing body facility's Health a risk plan in reg obtained clarific residuals, monite client's "diaper re clients' doctors w Medication Adm	ody failed to ensure the Care Services met the The client. The failed to ensure the Care Services developed gard to the client's health, ation for monitoring ored and/or assessed a ash," and to ensure were aware the clients' ministration Records did recific time on when the						

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
	15G559	A. BUILDING B. WING		05/03/2013
			ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER		EVERLY DR	
ARC OF	NORTHWEST INDIANA INC, THE	GARY,	IN 46408	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	clients' medications were to be			
	administered to ensure the doctor agreed			
	with the facility's practice. The governing			
	body failed to ensure the facility's Health			
	Care Services ensured ordered			
	assessments were completed and a client's			
	fall risk plan was updated for clients #1,			
	#2, #3 and #4. The governing body failed			
	to ensure the facility's Health Care Services ensured staff were trained in			
	regard to aspiration pneumonia, peg tube			
	feedings and/or provided competency			
	based training to ensure all staff			
	understood and knew how to adequately			
	perform peg tube feedings and care for			
	client #3. The governing body failed to			
	ensure the facility's Health Care Services			
	administered all of client #2's medications			
	during a medication pass. Please see			
	W104.			
	9-3-1(a)			
	9-3-1(a)			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(x2) MULTIPLE CONSTRUCTION OUT DOIS 00			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
4D0 0E	NODTH WATER TAID	ANA INO THE			SEVERLY DR		
	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG W000104	483.410(a)(1)	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
VV00010 4	GOVERNING BO	DY					
		dy must exercise general					
		d operating direction over					
	the facility.						
		ation, interview and	W0	00104	Modifications to the way in wh	iich	05/31/2013
		r 2 of 2 sampled clients			the governing body exercises operating direction will be		
	` ′	for 2 additional clients			completed by 5/31/13 please		
	· //	governing body failed to			refer to Tags, W136, W140,		
	_	policy and operating			W148, W153, W157, W331,		
		e facility to ensure client			W342, W369		
		eeds were not neglected					
		health care services met					
	_	s of clients #1, #2, #3 and					
	•	ng body failed to exercise					
		nd operating direction					
	over the facility	to ensure the facility					
	allowed clients #	1 and #2 to participate in					
	community outin	ngs, to ensure client #3's					
	guardian was inf	formed of the client's					
	savings account,	and of the client's					
	inability to acces	s her own funds. The					
	governing body	failed to exercise general					
	policy and opera	ting direction over the					
	facility to ensure	the facility reported all					
	allegations of ab	use/neglect to the					
	administrator and	d/or to state officials for					
	client #3, and to	ensure the facility put in					
	place corrective	measures regarding an					
	allegation of neg	lect for client #3.					
	Based on intervio	ew and record review, the					
		failed to exercise general					
		ting direction over the					
	facility to ensure	the group home					

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		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G559	B. WIN			05/03/	2013
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST IND	DIANA INC. THE			EVERLY DR IN 46408		
	•				111 40400		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE		DATE
	maintained med	dical documentation as					
	related to Medi	cation Administration					
	Records for 1 o	f 4 sampled clients (Client					
	#2).	`					
	Findings includ	le:					
	1. On 4/16/13 a	at 11:49 AM, the facility					
	BDDS (Bureau	of Developmental					
		vices) reports were					
		4/16/12 to 4/1/13. A					
	•	abmitted 3/6/13 indicated					
		ssessed by the nurse due					
		excess coughing. The					
	_	Client #2 was congested					
		the emergency room. The					
	•	Client #2 was admitted to					
	_	h low oxygen levels and					
	was receiving o	oxygen.					
	On 4/16/12 of 1	:00 PM, Client #2's					
		ministration Record					
		March 2013 was reviewed.					
		cated several scheduled					
		ere marked as PRN (given					
		PRN medications for					
	· · · · · · · · · · · · · · · · · · ·	ninistered without					
	_	on the back of the result of					
	the PRN. The I	Nurse Manager was					
		4/16/13 at 2:35 PM. The					
	Nurse Manager indicated she would						
	clarify Client #2	2's physician orders and					
	return with the	MAR documentation. The					
	Nurse Manager	and the Service					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G559	B. WING			05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODTHWEST IND	IANIA INIC. THE			EVERLY DR		
	NORTHWEST IND	·			IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		ndicated they would also		IAG	,		DATE
		s January, February,					
		1 2013 physician orders					
		ng MARs for further					
	review.	ig MARS for further					
	icvicw.						
	On 4/18/13 at 1:	00 PM, a record review					
		icated client #2's					
		led, but were not limited					
	~	ation, Down Syndrome,					
	l '	ness in right eye, seizure					
	disorder, and dia						
	disorder, and did	locies.					
	On 4/18/13 at 2:	29 PM, Client #2's					
		work from her hospital					
		en 3/5/13 and 3/19/13					
		The discharge paperwork					
		#2 was admitted to the					
		piratory distress,					
	-	nonia, anemia, and shock					
		Hepatitis-decreased blood					
	,	The hospital discharge					
		ated Client #2 "presents					
		of cough and congestion					
	onset one day pr						
		port also states that					
		een wanting to eat for the					
	_	(prior to admission).					
	1 *	ever. Caregiver states the					
		bal, but has been whining					
	. ^	ays. States patient is					
	usually a very go						
		to not want to eat. States					
		became worse today."					
	1						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G559	B. WIN	G		05/03/2	2013
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	C.		2901 BE	EVERLY DR		
	NORTHWEST IND			GARY, I	N 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		25 PM, Client #2's					
	physician orders	for February, March, and					
	April 2013 were	received from					
	Administrative s	taff #1. Client #2's					
	MARs for Febru	ary and April were					
		dministrative staff #1.					
	On 4/22/13 at 5:	47 PM, Administrative					
		d no other physician					
		were located for Client					
		anuary 2013 physician					
		and March 2013 MAR					
	could not be loca	ated. No further					
	documentation v	vas presented.					
	2. The governin	g body failed to exercise					
	general policy as	nd operating direction					
	over the facility	to ensure the facility					
	implemented its	written policies and					
	procedures to pr	event neglect of client #3					
	in regard to aspi	ration pneumonia and					
	falls. Please see	*					
	3. The governin	g body failed to exercise					
		nd operating direction					
		to ensure the facility					
	1	\$1 and \$2 to participate in					
		community. Please see					
	W136.	Community. Thease see					
	W 130.						
	1 The governin	g body failed to exercise					
	1 2	nd operating direction					
	over the facility	to ensure the facility kept					

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE A. BUILDING B. WING	00	COI	TE SURVEY MPLETED 03/2013
	PROVIDER OR SUPPLIER		STREE 2901	T ADDRESS, CITY, STATE, ZI BEVERLY DR Y, IN 46408	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	finances as some	e financial records were review for clients #1, #2, se see W140.				
	general policy ar over the facility informed client # amount of funds account held by inform the client not able to access savings account	g body failed to exercise and operating direction to ensure the facility #3's guardian of the in the client's savings the facility, and/or to 's guardian client #3 was s her funds in the local as the client did not have lentials/paper work.				
	general policy are over the facility immediately reprossible neglect and/or failed to reglect to the Diagong and Reham (DDARS)/BDDD Developmental I 460 IAC 9-3-1 (Protective Service for client #3. Please of the policy are general policy are over the facility of the policy are over the facility of the facility of the policy are over the facility of	Disabilities Services) per b) (5) and to Adult ces (APS) per IC 12-10-3				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE : COMPL		
11112 12111	or condition.	15G559		LDING		05/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST IND	ANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ective measures and/or					
	•	ng in regard to an glect involving client #3.					
	Please see W157	_					
	Tiedse see Wisy	•					
	8. The governin	g body failed to exercise					
	_	nd operating direction					
	over the facility	to ensure the facility's					
	Health Care Serv	vices met the nursing					
		nt. The governing body					
		e general policy and					
		on over the facility to					
		y's Health Care Services					
		lan in regard to the					
	•	btained clarification for uals, monitored and/or					
	_	's "diaper rash," and to					
		octors were aware the					
		on Administration					
		specify a specific time on					
		medications were to be					
	administered to	ensure the doctor agreed					
	with the facility's	s practice. The governing					
	body failed to ex	tercise general policy and					
		on over the facility to					
		y's Health Care Services					
		assessments were					
	•	client's fall risk plan was					
	_	ats #1, #2, #3 and #4.					
	Please see W331						
	9 The governing	g body failed to exercise					
		nd operating direction					
		to ensure the facility's					
	<u> </u>	<u>-</u>					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		A. BUILDING B. WING			COMPLETED 05/03/2013	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE		2901 BE	.DDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	Health Care Services ensured staff were trained in regard to aspiration pneumonia, peg tube feedings and/or provided competency based training to ensure all staff understood and knew how to adequately perform peg tube feedings and care for client #3. Please see W342. 10. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health care Services ensured the facility administered all of client #2's medications during a medication pass. Please see W369. 9-3-1(a)						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE : COMPL	
		15G559	A. BUII			05/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	EVERLY DR		
	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46408		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFTING INFORMATION)		TAG			DATE
TAG W000122	483.420 CLIENT PROTECT The facility must of protections requir Based on observations for 2 and #2) and for 2 and #4). The fact written policy and meglect of client client's medical ratio ensure clients outings/activities ensure the facility accounting of client accounting of clients of client's saving allegations of about administrator and state law for client to ensure correct place to address the same correct place to address the same clients of the client's saving allegations of about the client's saving allegations of a	ensure that specific client ements are met. ation, interview and the facility failed to meet Participation: Client of 2 sampled clients (#1 additional clients (#3 cility failed to implement the difference of the procedures to prevent the difference of the facility failed to implement the meeds. The facility failed the facility failed the facility failed the community, to the graph of the procedure of the facility failed the measures were put in the facility failed the facility failed the measures were put in the facility failed the facility failed the facility failed the measures were put in the facility failed the facility failed the facility failed the facility failed the measures were put in the facility failed th	W0	TAG 00122	Methods of ensuring client protections have been revise by 5/31/13. Please see tags W149, W136, W140, W148, W157		05/31/2013
	_	ailed to implement its					
		and procedures to prevent					
	•	#3 in regard to aspiration					
	_	falls. Please see W149.					
	2. The facility fa	niled to ensure clients #1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN	G		05/03/2013
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIER			2901 BE	EVERLY DR	
	NORTHWEST IND	·		GARY,	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE
		ted in activities in the				
	community. Ple	ase see W136.				
	3. The facility failed to keep a complete					
	accounting of the clients' finances as					
		ecords were not available				
	to review for clients #1, #2, #3 and #4.					
	Please see W140).				
	A The Collin College of Comment and Water					
	4. The facility failed to inform client #3's					
	guardian of the amount of funds in the					
		account held by the				
		o inform the client's				
	_	² 3 was not able to access				
	her funds in the	local savings account as				
	the client did not	t have the required				
	credentials/paper	r work. Please see W148.				
	5 The facility fa	ailed to immediately				
	1	ion of possible neglect to				
		r and/or failed to report				
		neglect to the Division of				
	_	g and Rehabilitative				
	, , ,	S)/BDDS (Bureau of				
	`	Disabilities Services) per				
		b) (5) and to Adult				
	,	, · · ,				
		ces (APS) per IC 12-10-3				
	for client #3. Ple	ase see W133.				
	6. The facility fa	ailed to take appropriate				
	corrective measures and/or provide					
		ard to an allegation of				
	-	g client #3. Please see				
	W157.	5				
	1					I

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		IDENTIFICATION NUMBER: 15G559	A. BUILDING B. WING	00	COMPLETED 05/03/2013			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
IAU	9-3-2(a)	ESC IDENTIFITING INFORMATION)	IAU		DAIL			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		15G559	B. WIN			05/03/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				EVERLY DR		
ADC OF		IANIA INIC. THE					
ARC OF	NORTHWEST INDI	ANA INC, THE		GART,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000136	483.420(a)(11) PROTECTION O The facility must of clients. Therefore that clients have to participate in soci community group Based on intervious 2 of 2 sampled of facility failed to participated in accommunity. Findings include Client #2's record 4/18/13 at 1:00 F Logs from Februindicated client # any community a above mentioned Client #1's record 4/18/13 at 4:00 F Logs from Februindicated client # any community a above mentioned Interview with st PM stated "It has clients out into the indicated 2 staff."	F CLIENTS RIGHTS ensure the rights of all e, the facility must ensure the opportunity to ial, religious, and activities. ew and record review for lients (#1 and #2), the ensure the clients ctivities in the The diagram of the diag	W0	000136	The Service Coordinator will retrain staff to ensure that all clients have the opportunity to out into the community by 5/31/13. To ensure adherence this training an activity log will implemented at the home. Th log will be sent to the service coordinator weekly for three months and then twice a mont thereafter to ensure the clients continue to have regular community outings. The Behavior Health Director monitor the Coordinators recommonthly for three months and then periodically thereafter to ensure future compliance.	to be is h	05/31/2013

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	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
		15G559	A. BUII B. WIN	LDING G		05/03/	
			b. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ROVIDER OR SUPPLIER			2901 BE	EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	Interview with S #1 and administr at 5:00 PM indic clients #1 and #2 community. SC weekend try to ta weekend plans." and/or SC #1 did additional inform documentation w	ervice Coordinator (SC) rative staff #1 on 4/19/13 rated the group home took 2 on outings in the #1 stated "Every rake out. Should be in Administrative staff #1 I not provide any		IAU			DATE

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	A. BUI	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 05/03/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A 2901 BE	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W000140	system that assuraccounting of clie entrusted to the fa Based on record 2 of 2 sampled c 2 additional client facility failed to accounting of the some financial reto review. Findings include Client #1's financial recorded did not have "Busheets) in the hord December 2012 expenditures and client's account lead to the client #1's financial recorded did not have "Client #1's financial recorded did not in client's savings a records did not in client #2's financial recorded did not have "Busheets" account lead to the client's savings a client's savings a client's savings a client #2's financial recorded did not have "Busheets" account leads to the client when the client's savings a client #2's financial recorded did not have "Busheets" account leads to the client when the client's savings a client #2's financial recorded did not have "Busheets" account leads to the client when the client when the client's savings a client when the client when the client's savings a client when the client's savings a client's savings a client's savings a client's savings a client when the client's savings a clien	establish and maintain a res a full and complete ints' personal funds acility on behalf of clients. review and interview for lients (#1 and #2) and for ints (#3 and #4), the keep a complete e clients' finances as ecords were not available in the fords indicated the client diget Sheets" (financial me from April 2012 to of the client's lord deposits for the sept at the group home. It is count book and/or indicate the balance in the ccount.	W0	00140	A new procedure for maintainic client funds will be developed 5/31/13. The Service Coordin will train DSPs on this new system by 6/2/13. Staff will ne to demonstrate how to fill out these budget forms and bank reconciliations. These documents will be reviewed by the service coordinator every weeks and will be stored in a standardized location so that the are readily available. To ensure future compliance, Service Coordinator will notify staff and Area Manager if the client budget sheets and bank statements are not received the Monday after the budget periodends.	by ator ed y two they The the	05/31/2013

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN			05/03/2013
NAME OF F			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L		2901 BE	EVERLY DR	
	NORTHWEST INDI				IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE
	December 2012					
		l/or deposits for the				
		kept at the group home.				
	Client #2's financial records indicated the					
	client also had a savings account, but the					
	client's savings account book and/or					
	records did not indicate the balance in the					
	client's savings account.					
	Client #3's financial records were reviewed on 4/16/13 at 7:10 PM. Client					
	#3's financial records indicated the client					
		idget Sheets" (financial				
		me from April 2012 to				
	December 2012	-				
		d/or deposits for the				
		kept at the group home.				
		cial records indicated the				
		savings account, but the				
	1	account book and/or				
		ndicate the balance in the				
	client's savings a	ecount.				
	Client #4's finan	cial records were				
		6/13 at 7:10 PM. Client				
		cords indicated the client				
		adget Sheets" (financial				
		me from April 2012 to				
	December 2012					
	-	l/or deposits for the				
	client's account l	kept at the group home.				
	Client #4's finan	cial records indicated the				
	client also had a	savings account, but the				
		account book and/or				

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	OF CORRECTION OF CORRECTION 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00		TE SURVEY MPLETED 03/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 BI	ADDRESS, CITY, STATE, ZII EVERLY DR IN 46408	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	records did not indicate the balance in the client's savings account.				
	Client #1, #2, #3 and #4's financial records kept at the facility's office were reviewed on 4/19/13 at 2:53 PM. The financial records indicated the facility did not have budget sheets with receipts/expenditures for April 2012, May 2012, June 2012, July 2012, October 2012 and November 2012 for clients #1, #2, #3 and #4. Interview with staff #1 on 4/16/13 at 7:10 PM indicated clients #1, #2, #3 and #4 had no financial records/Budget Sheets for 2012 in the group home. Staff #1 indicated she had sent the sheets into the office. 9-3-2(a)				

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (l í	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
		15G559	B. WING		05/03	3/2013
	ROVIDER OR SUPPLIER		2901 E	TADDRESS, CITY, STATE, ZIP COI BEVERLY DR 7, IN 46408	DE	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W000148	PARENTS & The facility must parents or guardianicidents, or charincluding, but not accident, death, a absence. Based on intervirula additional client to inform the client amount of funds account held by inform the client not able to accessavings account the required credit Findings included Client #3's record/17/13 at 11:41 Individual Supportient #3's brother guardian. Client #3's finance wiewed on 4/16/19/13 at 2:53 If Statement of Acchad a savings account a savings account the required credit #3's finance of \$1,30 in the savings account	d was reviewed on AM. Client #3's 8/16/12 ort Plan (ISP) indicated er was the client's cial records were 6/13 at 7:10 PM and on PM. Client #3's 3/31/13 count indicated client #3 count. The 3/31/13 ted client #3 had a	W000148	The Service Coordinator the clients valid state IDs 5/31/13. This client's Guardians been notified of the lin her savings account. To ensure future compliants behavioral Health Directore-train all Service Coordon notifying Guardians of changes in financial or modition by 5/31/13. The Coordinators will create all clients and the dates in their IDs expire to ensure renewed prior to expiration	s by ardian balance ance, the or will dinators f all nedical e Service a list of in which e they are	05/31/2013

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	(X3) DATE : COMPL	
		15G559		LDING		05/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
		ent #3's bank would no					
	_	group home to present a					
		nt to access her savings					
	account at the bank. Staff #1 indicated the group home had been presenting the						
		*					
	letter to get money out of the client's						
	savings account. Staff #1 indicated client #3 was not able to sign her name. Staff						
		nt #3 did not have a valid					
state identification card to take to the							
bank to access her money. Staff #1 indicated the client's state identification							
	•	2007 when the client was					
		home. Staff #1 stated					
		otor Vehicles would not					
		s state identification card					
		ne "waited to late" to					
		state identification card.					
		d client #3 would have to					
	•	ertificate and social					
		he state agency to obtain					
	a new identificat	ion cara.					
	Interview with c	lient #3's guardian on					
		AM indicated he would					
		B's social security check					
		ch month. When asked if					
	_	s aware of client #3's					
		the guardian stated "Not					
	_	The guardian indicated					
		make much at the					
	workshop.						
	1						
	9-3-2(a)						

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	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 03/2013
	ROVIDER OR SUPPLIE NORTHWEST IND		2901 BE	ADDRESS, CITY, STATE, Z EVERLY DR IN 46408	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE ACTI CROSS-REFERENCED TO ' DEFICIENC	ON SHOULD BE	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G559	B. WIN			05/03/2013	
			D. 17111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, IN 46408			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	Е
W000149	483.420(d)(1)	ENT OF CLIENTS					
		develop and implement					
		nd procedures that prohibit					
		glect or abuse of the client.					
	Based on observ	ation, record review and	W0	00149	The Behavioral Health Directo	05/31/	/2013
		f 2 sampled clients (#3),			will review reporting and		
		cted to implement its			investigation requirements for		
		and procedures to prevent			Abuse, Neglect (including the		
	•	#3 in regard to aspiration			neglect of medical care), Exploitation and injuries of		
	pneumonia and f	•			unknown origin of clients with	he	
	pricumoma and i	ans.			Service Coordinator and DSPs		
	Findings in stude				that are involved with Beverly		
	Findings include				by 5/31/13. In order to identify	l l	
	1 771 0 111 1				other areas of concern all other Coordinators will be trained or		
	_	reportable incident			reporting and investigation		
		Incident/Accident (I/A)			requirements for Abuse, Negle	ct.	
	•	nvestigations were			and Exploitation.	,	
	reviewed on 4/16	6/13 at 2:29 PM. The			In order to prevent		
	facility's reportal	ole incident reports, I/A			reoccurrences, posters explair	ing	
	reports and/or in	vestigations indicated the			client rights and reporting requirements have been made		
	following:				and distributed to all group hor		
	-				and the day program so that s		
	-3/8/13 at 12:23	PM, "Staff noticed [client			and clients become more awa		
		d is breathing different			of the requirements on an		
	-	o her nose being stopped			ongoing basis. Additionally, al	l l	
		ction Taken" section			staff will be trained on reporting		
	•	s seem that she has a cold			and investigation requirements Abuse Neglect, and Exploitation		
					at least annually unless chang		
	_	r meds of nasal spray			occur or need requires this to		
	` ′	Il seems that her nose is			done more frequently.		
	. , ,	y service Health & (and)			To ensure that Service		
	_	n) call (sic) the nurse to			Coordinators are trained on		
		ssess." The I/A indicated			reporting and investigation requirements for Abuse Negle	₋₁	
	the Health & Saf	Pety technician assessed			(including the neglect of medic		
	the client on 3/8/	13 at 12:55 PM and			care), Exploitation and injuries		
	called the nurse	on 3/8/13 at 12:10 PM			unknown origin the Behavioral		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		15G559	A. BUII B. WIN			05/03/2013	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC. THE			IN 46408		
			_		114 40400		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE	į.
	` ′	3 I/A did not indicate the			Health Director will review thei		
	facility's nurse as	ssessed the client.			training records at least annua and document review of finding	· .	
					Area Managers will review DS		
	-3/14/13 "The st	aff noticed when [client			training records to ensure they		
	#3] came in she	was shaking and not			have been training at least		
	_	l looking right. the (sic)			annually and document review	of	
	_	health tech (technician).			findings. All new Service		
	The health tech t	` /			Coordinators and DSPs will be		
		ch was a high temp			trained on reporting and investigation requirements for		
		C 1			Abuse Neglect (including the		
	, ,	nediately called the			neglect of medical care),		
		. The health tech tried			Exploitation and injuries of		
] crushed Tylenol (fever)			unknown origin prior to working		
	with applesauce	but she would not take it.			home or with a client. In addit		
	911 was called.	The nurse took [client			the Service Coordinators will b		
	#3's] temperature	e which was 103.8. The			present in their homes at least two times per month to ensure	I	
	nurse assessed [c	client #3] by checking her			protection of clients, address		
	lungs which was	s (sic) clear and checking			concerns, monitor activities, et	c.	
	_	ich was soft. The EMT's			Documentation of visits will be		
		dical Technicians) arrived			completed and will include		
	and took [client:	*			specifics to the client as well a		
	_				the visit. The Behavioral Heal Director will review visitation to		
	hospital]."				weekly and once a pattern of	ys	
		1/10 T/1 B			regular visitation and observat	on	
		4/13 I/A Report indicated			is established reviews of visita		
	_	he day program, staff			logs will fade to quarterly.		
	noticed a "chang	e in physical					
	condition/injurie	es" with client #3.					
	The facility's 3/1	4/13 Investigation Fact					
		and Conclusion indicated					
	1	ssible Neglect-Consumer					
	_	to Day Services and					
		ethargic. Res (residential)					
	_	at client was a little extra					
	tired on Thursda	y morning. Staff had to					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	15G559	A. BUI	LDING	00	COMPL 05/03/	
		100000	B. WIN			05/03/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			EVERLY DR IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ast 4 times during					
		norning staff got client					
	1 -	nop-client took morning					
		pplesauce & took blood					
	pressure 106/62.						
		t ate about 3/4 of					
		had to keep waking client					
		ast. Staff reported that					
		y the previous nurse that					
	client would hav	e good days & bad days					
	and some days w	ould seem a little extra					
		er picked client up and					
	was told by staff	that client did not eat all					
	of her breakfast.	Med driver stated, that					
	client had no not	iceable behaviors.					
	During the past 3	3 days, Res staff					
	noted-Monday c	lient was alert & trying to					
	feed self. Tuesd	ay client was doing a lot					
	of sleeping and h	nad to wake client up to					
	feed her. Wedne	esday client was feeding					
	self with her han	ds for breakfast. Staff					
	fed her dinner in	the evening. She ate a					
	lot of her dinner.	Midnight staff noted					
	that client did no	t wake up during the					
	night. Nurse did	not receive any phone					
	calls/pages in the	e last 72 hours. Client					
	did seem a little	more tired per staff the					
	morning of 3-14	-13 but this is not out of					
	the ordinary for	client. Re (resident) staff					
	was told by prev	ious nurse that this is to					
		client. Med driver did					
	not notice any di	fferent behaviors from					
	client the morning	ng of 3-14-13." The					
		ation indicated "The					

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If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CC A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 03/2013
	PROVIDER OR SUPPLIER		STREET A 2901 BI	ADDRESS, CITY, STATE, ZIP EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	allegation is not recommendation by Day Services	true" The facility's as indicated "No neglect staff. Staff should return tion not substantiated"				
	indicated she (st driver client #3 of breakfast and that cold. Staff #1's indicated staff # "and wrote that congested, even (congestion) pill was alert and try Tuesday she was I had to wake he by the nurse that [client #3] would	aff #1) had told the med did not eat all her at client #3 still had a witness statement 1 filled out a daily log t she (client #3) was still with taking the Sudafed sOn Monday [client #3] ring to feed herselfOn a doing a lot of sleeping. It to feed herI was told thad our house that d have good days and bad to be expected with her				
	indicated the sta shift and checked different times of statement indica	ss statement by staff #3 ff worked the overnight d on client #3 three n 3/14/13. The witness ted client #3 slept t, and "I (staff #3) unusual"				
	driver indicated to the workshop	ss statement with the van he transported client #3 on 3/14/13. The van "I was told that client did				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	15G559	A. BUILI	DING	00	COMPL 05/03/	
		13G339	B. WING			03/03/	2013
NAME OF F	PROVIDER OR SUPPLIER	L			DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			VERLY DR N 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	~	er [staff #1]). No					
		vior. 9:45 [Name of					
		an] asked why did I bring					
	client in. Response Client did not eat						
	much."						
		ss statement by staff #4					
		#3 did not "look right"					
		came in to work on					
	3/14/13. The wi	tness statement indicated					
		shaking like she was					
	cold" Staff #4	l's witness statement					
	indicated "This	s week I noticed she					
	wasn't breathing	right. I did incident					
	report on it. The	e nurse from main came					
	to look at her the	en they returned her back					
	to the room"						
		ss statement with the					
		indicated she checked					
	client #3 as staff	had complained client #3					
	was shaking and	cold. The witness					
	statement indica	ted the temperature was					
	103.5 and she (th	ne health tech)					
	immediately call	ed LPN #1 who "said					
	1	ng to a meeting (sic) &					
	she would let [L	PN #2] know (sic)"					
		ement indicated the					
	health tech then	went to give the client					
	crushed Tylenol	in applesauce which					
	client #3 did not	take. The witness					
	statement indica	ted she then had LPN #2					
	paged at 9:45 an	d told her "to come					
	right away cause	e [client #3] was real					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		15G559	B. WIN			05/03/2013
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	C		2901 BE	EVERLY DR	
	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)	DATE
	sick"					
		ss statement with				
	_	nator] (SC) #3 indicated				
		red any calls from group				
	-	[client #3]. I did not				
	know she had a	cold until I received the				
	logs from nurse.	"				
	A 3/15/13 witne	ss statement by staff #2				
	indicated "We	d (Wednesday) evening				
	[client #3] seem	(sic) to have a pretty				
	decent evening h	nowever, she was a little				
	T	ne evening she sat up &				
		she spoke 2 to 3 words.				
		ed on Thursday morning.				
	I	the her out of her room,				
		e extra tired. Staff gave				
		took her blood pressure.				
	_	r the reading exactly but I				
		was in the normal				
	~	ritness statement by staff				
	_	revious nurse had told				
		ould "be tired off and				
	on."					
	A 3/15/13 witne	ss statement by the Nurse				
		ndicated she had been				
		2 on 3/14/13 indicating				
	_	-				
		having the shakes &				
		as going over to check				
		shortly after & said it was				
	I -	rgic, unable to swallow				
	Tylenol. To call	911. I told her to do a				

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	T OF DEFICIENCIES	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) N			NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	00	COMPL	
		15G559	B. WING			05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	N 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	Т	TAG	DEFICIENCY)		DATE
	physical assessm						
	` ′	le before leaving to hosp					
	(hospital) [LPN #2] later told me she						
	checked her lung	gs x (times) 2 & they were					
	clear. I had the	nurse cell phone & did					
	not receive any o	calls the last 12 hours."					
	The facility's har	nd written undated					
	investigative not	es indicated "Res staff					
	knew she had a c	cold, giving					
	Sudafed-putting	on logs1 staff aware					
	client had been o	congested earlier in week-					
	No neglect-possi	ible poor					
	communication.	' The facility's 3/14/13					
		t neglected to include any					
	corrective measu	_					
		nunication. The facility's					
		o failed to address the					
	facility's nursing						
		or follow-up in regard to					
	the 3/8/13 daily						
	1	ent was having difficulty					
		_					
		acility's investigation also					
	_	ress the lack of reporting					
		o the nurse in regard to					
	PRN usage.						
	G1:	. 1 1					
		tal records were reviewed					
		00 PM. Client #3's					
	`	ergency department)					
		he chief complaints in the					
	ER (emergency	room) were the following:					
	"-Fever						

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Event ID: W6DF11

Facility ID: 001073

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G559	B. WIN	G		05/03/2	2013
NAME OF F	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE, ZIP CODE		
450.05	NORTH WATERT IND				EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	N 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)	1	DATE
	-Shortness of Br						
		or purplish discoloration					
	of skin)	G1					
		She was sent here					
		and low oxygenation. It					
		w long her symptoms					
	_	" The ED note indicated					
	1 * *	ompleted in the ER. The					
		ed the following (not all					
	inclusive):						
	` .	sure) 78/36/Pulse 79/					
	• • •	F (Fahrenheit) (39.1 C					
	` ' `	l)/ Resp (respirations)					
	• •	oxygen) 78%" The					
	ED note indicate						
		had "Mottled (patches of					
	skin irregular in	-					
		The 3/14/13 ED note					
	indicated "Patier						
	hypotension and	fever and clinically					
	consistent with s	epsis. We'll get labs,					
	lactic acid and b	lood cultures. We'll give					
		fluids and look for					
	`*	ent) has infiltrate on right					
	sidealso w/UT	TI (Urinary Tract					
	Infection)Dx ((diagnosis) sepsis					
		eumonia, UTI." Client					
	#3's ED note ind	icated client #3 was					
	admitted to the h	nospital's Intensive					
	Medical Care Ui	nit.					
	Client #3's 3/15/	13 Infectious Disease					
	Consult Note inc	licated client #3 had					
	"Mild patchy pn	eumonia in the right mid					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 05/03	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	regions in lung by pneumonia bilated note indicated classificated and needed to be connote indicated a was ordered. Client #3's 3/18/Study indicated (Modified Barius completed on 8/2 recommendation diet/mechanical thin liquids." The #3 was not able directionsNeet delayed cough as straw) Puree:Pl and delayed cough swallow)Reconswallow to r/o (recommend keemouth)" Client #3's 3/19/Language Pathol (Cookie) Swallow evaluated (Bedside) Swallow Swal	lateral hilar and perihilar basesdevelopment of berally" The consult iient #3 had bilateral aspiration pneumonia asidered. The consult swallowing evaluation 13 Clinical Swallow "Previous MBS m Swallow) was 22/12 with a for ground soft (gravy to meats) and he study indicated client to follow ar: Pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration). The pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration). The pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration). The pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration). The pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration). The pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration). The pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration). The pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration). The pharyngeal (slightly fiter the swallow with a haryngeal: (intermittent gh after the mmend modified barium rule out) aspiration).						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		15G559	B. WIN			05/03/2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	C		2901 BE	EVERLY DR	
	NORTHWEST IND			<u> </u>	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	DATE
	_	known Modified Barium				
	1	8/22/12 revealed no				
	aspiration or laryngeal penetration but					
		geal residue which patient				
		ed independently with via				
	dry swallow." T	The MBS indicated client				
	#3 was not able	to follow commands.				
	The MBS indica	ated the following (not all				
	inclusive):					
	, in the second second					
	"Consistencies A	Assessed:				
		al: Delayed Swallow.				
		penetration during the				
	swallow.	penetration daring the				
	Swanow.					
	Nectar Pharyno	geal: Cough-Immediate				
		sensing pharyngeal				
	residue after the					
	residue after the	swanow.				
	Duraa Dharanaa	eal: Cough-Immediate due				
		•				
	_	g pharyngeal residue after				
	the swallow.					
	 SolidPharvnge	eal: Cough-Immediate due				
		g pharyngeal residue after				
	•	The 3/19/13 MBS				
		#3 had "Pharyngeal				
		lerate Risk of Aspiration				
		sic) Orally dysphagia,				
	`	, , , , , , , , , , , , , , , , , , , ,				
		phagia, and Cognition				
		Swallowing Strategies:				
		ollow commands or				
	compensatory					
	techniquesRec	commendations: Diet	\perp			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G559	B. WINC			05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODTHWEST IND	IANIA INC. THE			EVERLY DR		
	NORTHWEST IND	·			IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		ns NPO: Yes, due to		IAG	,		DATE
		y to use compensations					
	for safety. Speed	*					
		recommended due to					
	_	y to follow commands for					
	l ^	tory techniques for					
	safety."	ttory teeninques for					
	saicty.						
	A 3/20/13 Physic	cian Progress Note					
	1	ent's condition is					
		cookie swallowPlan 1.					
	For (sic) Peg (fe						
		eaming tube).					
	Client #3's 3/21/	13 Modified Barium					
		w impression indicated					
	` ′	oisode of laryngeal					
	penetration seen	2 0					
		ip cup. No aspiration					
	1 ^	amination showed no					
		ation or aspiration. Stasis					
	in vallecula (chr	-					
	`	(oral part of the airway)					
	dysphagia) persi						
		ssessment/Plan:Keep					
		y mouth) for now. Patient					
		g. Speech therapist					
		Patient failed cookie					
	swallow. For PI						
	Client #3's 3/22/	13 Gastroenterology					
		dicated a "Pre-procedure					
	1 2	ysphagia [787.20] 2.					
		in adult [783.7]." Client					
		ords indicated nursing					
	· r						

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
ANDILAN	15G559	A. BUILDING	00	05/03/2013
	100309	B. WING	DDDDGG GYMY GM :	00/00/2010
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE EVERLY DR	
ARC OF	NORTHWEST INDIANA INC, THE		IN 46408	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	staff was monitoring for residuals while			
	the client was in the hospital.			
	Client 3's 3/27/13 Discharge Summary			
	indicated client #3 was on bolus tube			
	feedings. Client #3's discharge diagnoses			
	included, but were not limited to, Sepsis,			
	Bilateral Pneumonia" The note			
	indicated "Pt was started on IV antibiotics			
	and IVF (intravenous infusion). She was			
	very lethargic initially but soon became			
	more with it. She however failed cookie			
	swallow and had to get a peg tubeCXR			
	(sic) (chest X-ray) done 22/ (sic) showed			
	worsening pneumonia and pts (sic) was			
	referred to LTAC (long term acute care)			
	admission for continued IV antibiotics.			
	Brother would not hear of that so her			
	antibiotics was (sic) changed to po (by			
	mouth) and py (unidentified) is going			
	back to group home." Client #3's 3/28/13			
	Patient Demographics sheet indicated the			
	client was discharged to the group home			
	on 3/28/13. The demographics sheet			
	indicated client #3's Final Diagnoses also			
	included, but were not limited to,			
	Septicemia (serious life threatening			
	infection), Cyanosis, Dysphagia, Adult			
	Failure to Thrive and Dehydration. Client			
	#3's hospital records indicated the client			
	was admitted for Septicemia, Pneumonia			
	and Acute Respiratory Failure in 12/20/11			
	through 1/3/12.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	15G559		LDING	00	05/03/	
		100000	B. WIN		PPPPG GWW GW == ===	03/03/	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		13 observation period					
		1 and 7:30 PM, at the					
		ent #3 sat in a wheelchair.					
		f#1 took client #3 to her					
		her her medication via					
		then to do the client's					
		taff #1 placed a syringe					
		to check for residual.					
		the syringe to 30 and then					
		then used a small					
		to flush client #3's peg					
	tube. Staff #1 po						
		ations into the syringe,					
		red 2 cans of Jevity, a					
	little at a time, in	to the syringe. Staff #1					
	l '	peg tube, with the					
		e 300 cc of water after the					
	~	#3's peg tube opening had					
	l -	e raw opening. Interview					
	with staff #1 on	4/16/13 at 6:15 PM stated					
	she was instructed	ed to only "pull up					
	halfway and stop	o." The syringe had					
	cloudy liquid up	to the 30 mark. Staff #1					
	indicated they di	d not measure residual					
	amounts. Staff #	⁴ 1 stated they could feed					
	the client as long	g as the liquid in the					
	syringe did not h	ave "Jevity (liquid food)					
	color." Staff#1	indicated client #3's peg					
	tube opening wa	s cleaned every morning.					
	Staff #1 stated "a	a little blood is ok. If					
	smell or drainage	e changes color, call					
	nurse." Staff#1	stated she used a "Q-tip"					
	to clean around t	he opening. Staff #1					
	picked up a wasł	n cloth which was on the					
	l						

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If continuation sheet

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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE ARC OF NORTHWEST INDIANA INC, THE SIRRET ADDRESS, CITY, STATE, ZIP CODE 2001 BEVERLY DR GARY, IN 46408 SIRRET ADDRESS, CITY, STATE, ZIP CODE 2001 BEVERLY DR GARY, IN 46408 ID GARY, IN 46408 ID GARY, IN 46408 ID GREGUATORY OR LSC IDBNITRYING BNORMATION) TAG dresser and said some staff used a wash cloth, Staff #1 stated the wash cloth was "abrasive." Client #3's record was reviewed on 417/13 at 11-41 AM. Client #3's Daily Logs indicated the following (not all inclusive): -3/4/13 "[Client #3] coughing & nose running. Robafen given @ (at) 5-48. Push fluids had to be fed by staff. Very large BM (bowel movement)." -3/5/12 BP (blood pressure) 100/68 P (pulse) 70 Nothing else documented on form. -3/12/13 BP 110/68 Nothing else documented on form. -3/14/13 BP 106/62 P 74 "She is still coughing and she sounds congestion (sic). We are still giving her Sudafed, had to wake her up at least four times this AM for breakfast." The daily log neglected to indicate the nurse was called in regard to the client's change in health status. Client #3's 1/13 to 3/31/13 to 3/31/13 Medication Administration Record (MAR) indicated	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL		
ARC OF NORTHWEST INDIANA INC. THE (X4) ID PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY PULL) TAG REGIDATORY OF IS DEMINIFACING INFORMATION.) (Action Staff #1 stated the wash cloth was "abrasive." Client #3's record was reviewed on 4/17/13 at 11-41 AM. Client #3's Daily Logs indicated the following (not all inclusive): -3/4/13 "[Client #3] coughing & nose running. Robafen given @ (at) 5-48. Push fluids had to be fed by staff. Very large BM (bowel movement)." -3/5/12 BP (blood pressure) 100/68 P (pulse) 70 Nothing else documented on form. -3/12/13 BP 110/68 Nothing else documented on form. -3/14/13 "[Client #3] by 10/62 P 74 "She is still coughing as he sounds congestion (sic). We are still giving her Sudafed, had to wask cher up at least four times this AM for breakfast." The daily log neglected to indicate the nurse was called in regard to the client's change in health status. Client #3's 3/1/13 to 3/31/13 Medication	THEFTERN	or condition						
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Client #3's 3/1/13 to 3/31/13 Medication			_					
		the client's chang	ge in health status.					
		Client #3's 3/1/1	3 to 3/31/13 Medication					
Administration record (MAR) indicated								

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Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		15G559	B. WIN			05/03/	2013
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIC. THE			EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	N 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ГЕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ed Saline Mist 1 spray in					
		mes a day for congestion.					
		MAR indicated client #3					
	had a PRN (as n	, , , , , , , , , , , , , , , , , , ,					
		e (Sudafed) 30 milligrams					
		every 4 hours as needed					
	for nasal conges	tion. Client #3's MAR					
	also indicated th	e client had a PRN order					
	for Robitussin co	ough syrup 2 teaspoonfuls					
	every 4 hours PI	RN for chest congestion					
	or cough. Clien	t #3's 3/13 MAR					
	indicated the clie	ent received the					
	following:						
	-3/4/13 Robituss	sin cough syrup at supper					
		cough. The back of the					
		PRN is documented with					
	Reason & Resul						
		f the Robitussin was only					
	documented onc	•					
	documented one	C 011 3/4/13.					
	2/6/12 Sudafad	at bedtime for nasal					
		at bedtime for masar					
	congestion.						
	2/7/12 8 1-5- 1	in the meaning (1					
		in the morning (nasal					
		unch and bedtime					
		e lunch dose was not					
	documented on 1	the back of the MAR.					
	2/0/12 5 1 5 1						
		in the morning for					
	coughing						
		sin in the morning for					
	cough.						

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Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE CO	ONSTRUCTION 00	COM	TE SURVEY MPLETED 03/2013	
			B. WING STREET A	ADDRESS, CITY, STATE, ZIF	_	00,2010
	PROVIDER OR SUPPLIEF NORTHWEST IND			EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
1/40	-3/9/13 Sudafed congestion. The indicated the nur and told to give -3/10/13 Sudafed and bedtime for -3/11/13 Sudafed bedtime for cong MAR indicated reason and resulting bedtime for congestion. Client #3's 3/28/indicated client and congestion. Client #3's 3/28/indicated client and congestion.	at supper and bedtime for a back of the MAR rese was called at 4:00 PM 2 tablets. If in the morning, lunch congestion. If in the morning and at gestion. The back of the staff did not document the staff did not document the transfer for the morning and at gestion. If in the morning for a physician orders for the morning for t	IAU			DATE
	regarding wheth	to clarify/obtain an order er or not residuals should sured prior to feedings.				
	Client #3's Cum	ulative Medical Record				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/03/2013
	PROVIDER OR SUPPLIE		STREET . 2901 B	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	(doctor and nurs following (not a	se notes) indicated the all inclusive):			
	-2/20/12 Client evaluated for Ho	#3 had an order to be ospice services.			
	-2/21/12 Client Hospice program	#3 was accepted in to m.			
	-8/14/12 "Cookie Swallow not done due to not wearing her harness. Will be rescheduled."				
		nas no instance of Aspiration. Complete			
	evaluation. The	Ears, Nose Throat) e doctor recommended ue Saline Mist spray.			
		#3 went to her family f3's doctor indicated client clear.			
	[Client #3] temp W/C (wheelchai shaking. Very I Lungs clear bila non-tender Bow up by [name of	d to North workshop. o 103.8. Slouched over in ir). Appears pale & ethargic. Called 911. sterally, Abd soft, rel sounds present. Picked company] ambulance. fname of hospital] ER			

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G559	B. WINC	3		05/03/	2013
NAME OF B	ADOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		2901 BE	EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	I C	DATE
	(emergency roor	n).					
	, ,						
	-3/14/13 Admitte	ed to [name of hospital]					
	for observation &						
	101 00501 (411011 0	z troutinent.					
	Client #3's Cum	ulative Medical record					
		cate the facility nurse					
	assessed and/or of	-					
		ient #3 on 3/8/13 when					
		wing difficulty breathing.					
		Record and/or client #3's					
	_	to indicate the facility					
		e nurse of the above					
		usage with the client					
	_	Nasal Spray 4 times a					
	day. The facility	's nursing services					
	neglected to mor	nitor client #3 and/or					
	assess the client	on 3/4/13 when the daily					
	log was received	l, and/or assess the client					
	on 3/9/13 when s	staff called the nurse					
	about the client's	s congestion. The facility					
	neglected to ensi	ure a system was put in					
	place which ensu						
	•	usage of clients to ensure					
		lients' health were					
	performed as nee						
	portormed as nee						
	 Client #3's 8/16/	12 Medical Review					
		ated client #3 was					
		12/21/11 for Pneumonia.					
	-						
	The worksheet indicated "2 attempts @						
	cookie swallow 8/2 and 8/14 (2012)."						
	Client #21- 2/7/1	2 Ossantanlar Nassasia					
	Chent #3's 3///1	2 Quarterly Nursing					

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		15G559	B. WIN			05/03/2013	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST IND	IANIA INIC. THE			EVERLY DR IN 46408		
		·		<u> </u>	111 40400	<u>, </u>	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	т.
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE	1
1110		cated client #3 was a		0			
		Client #3's record did not					
		ient #3 stopped receiving					
	Hospice services						
	liospies services	•					
	Client #3's 8/11/	11 typed letter from the					
		ist indicated "The above					
	·	s) suffers from Down's					
		m, mental retardation and					
		are all contributing					
		agnosis of Dementia"					
	Client #3's undat	ted Caring For A J-tube					
	And When To C	all Your Nurse and/or					
	911 sheet indica	ted "[Name of another					
	client not from the	his group home] has a					
	Jejunostomy (J-t	ube) which is a procedure					
	that creates a sm	all opening through the					
	outer stomach in	to the small intestines1.					
	Gather all suppli	es needed: medications,					
	water, gloves, 30	Occ (cubic centimeter)					
	med cup, pill cru	isher, syringe with bottle,					
		al precautions (wash					
		d after each task and					
		Check the skin around					
	1	of infection. These may					
	include:						
	-Site is more ten	•					
	-Increased redne						
	_	green in color or foul					
	smelling odor						
	-Excessive leakage around the tube. **If						
	1	of the above signs of					
	infection contact	your nurse immediately.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G559	B. WIN			05/03/	2013
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	DIANA INC, THE			EVERLY DR IN 46408		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		at you keep the skin					
		clean and dry. Clean the					
		site with plain water**If					
	_	client] J-tube is pulled out					
		MEDIATELY. **If J-tube					
		ed or clogged and staff					
		it call your nurse and the					
	nurse will give						
		At the top of the undated					
		et, a hand written statement					
	indicated "World	k Instructions for Peg & J					
	tube feedings."						
	An instruction s	sheet for giving					
	Medications an	d Feedings with J-Tube or					
	Peg Tube indica	ated "2. Checking for					
	placement of th	e J-tube or peg tube staff					
	will need to pla	ce the stethoscope on the					
	client stomach	above the tubing, remove					
	the knob from t	ubing and insert the					
	syringe into the	tubing use the bulb and					
	slowly inject air	r into the tubing. Staff					
	will hear a gurg	ling sound which will let					
	you know the to	ubing is in the correct					
	spot" The in	structions sheet indicated					
	facility staff we	ere to flush the tube with					
	30ml of warm t	ap water before all					
	feedings or med	dications to ensure the peg					
	tube was not clogged. The instruction						
	sheet also indicated crushed pills were to						
	be dissolved in 15cc of warm tap water						
	and then flush with 15cc of warm tap						
	water. The inst	ruction sheet also					
	indicated the pe	eg tube was to be flushed					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		15G559	B. WIN			05/03/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
4DC OF	NODTHWEST IND	ANA INC. THE	2901 BEVERLY DR GARY, IN 46408				
	NORTHWEST INDI	ANA INC, THE		GARY,	IN 40408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	DEFICIENCE TY		DATE
		rm tap water after each					
		ove mentioned undated					
		s were located in a folder					
	in client #3's bed	room for staff to refer to.					
	C1: //21 - 0 /1 //	12 I. 1: 11 -10					
		12 Individual Support					
	` ′	ated the facility neglected					
		#3 had the diagnosis of					
		SP and/or record					
		ility neglected to develop					
		For the client's Dementia					
		ecline in health. Client					
		ated the facility neglected					
	_	plan for the client's					
		nagia which included how					
	1	d monitor the client to					
	prevent aspiratio						
		Elient #3's 8/16/12 ISP					
		ility neglected to include					
		for the peg tube which					
	_	lient #3, reflected the					
		/1/13 physician's order					
		ount water ordered), how					
		be checked/monitored,					
	1 1	indicated how the peg					
		as to be cleaned. Client					
		indicated the facility					
	_	elop specific instructions					
	_	facility staff were to					
		nent of the peg tube (if					
		ow staff should attempt					
	_	gged tube. Client #3's					
		d indicated the client's					
	IDT (interdiscipl	inary team) had					
							l

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Event ID: W6DF11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF I	PROVIDER OR SUPPLIE	ER.	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST IND	DIANA INC, THE		GARY,	IN 46408		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	Diricilité 1 y		DATE
		eet to review client #3's ensure the client's health					
	needs were add						
	needs were add	ressed.					
	The facility's tip	me cards were reviewed on					
	-	PM. The facility's time					
		al Shifts Worked by					
		dicated staff #7, #8 and #9					
	•	he group home since client					
		he group home with a peg					
	tube on 3/28/13						
	1400 011 3/20/13	•					
	The facility's in	service/training records					
	_	on 4/16/13 at 11:47 AM.					
		dividual Training/Group					
	_	t indicated the facility's					
		d an inservice on 3/28/13,					
		the group home, for 2					
		ing Tube." The inservice					
		LPN #1 conducted the					
		facility's Individual					
	_	ts indicated staff #7, #8					
		been trained in regard to					
		ing tubes/health needs.					
	Staff #9's 3/28/	•					
		Report indicated "[Client					
		eg (regular) food, 5cc					
		60 water (sic) Must stay					
		, Turn (sic) 2 hr., Change					
		very night. Call 911 if pull					
	tub (sic) out." The form indicated "Were						
	the materials provided effective? No."						
	The 3/28/13 form indicated staff #10						
		ot comfortable doing it."					
	1	3					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	<u>'</u>			TAG	DEFICIENCY)		DATE
	l '	gned by the staff's					
	_	form neglected to					
		0 was provided additional					
	_	stand and/or perform the					
		nt/procedure to the best of					
	I -	iew of the 3/28/13 staff					
	inservice forms i	indicated facility staff had					
	been told to disso	olve the client's					
	medications in 5	cc of water versus the					
	15cc of water as	indicated by the undated					
	instruction sheet	S.					
	The facility's ins	ervice/training record					
	indicated day ser	rvice program staff were					
	trained in regard	to client #3's feeding					
	I -	or 20 minutes by LPN #1.					
		4/8/13 training reports					
		cate the nursing services					
	_	etency based training					
	-	ked off staff) to ensure					
	,	stood how to care for					
		ibe and/or do peg tube					
		cility's training reports					
		e facility neglected to					
	I	aff were trained in					
	regards to aspira	uon/aspiration					
	pneumonia.						
	Intomvio	to ff #1 on 4/16/12 -4 0:20					
	Interview with staff #1 on 4/16/13 at 8:20						
	AM and at 5:55 PM indicated client #3						
	had not been feeling well for 2 weeks						
	prior to hospitalization. Staff #1						
		‡2 had pneumonia first					
	and then client #	3 got the pneumonia.					

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Event ID: W6DF11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G559	B. WIN			05/03/2	2013
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
4D0.0E	NODEL WATER IND	IANIA INIO THE			EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG	 			IAG	Birtelinery		DATE
		ed client #3 had a peg tube not do well on a cookie					
		aff #1 indicated facility in regard to client #3's					
		_					
	peg tube feeding	S OH 3/40/13.					
	Interview with a	taff #6 on 4/16/13 at 3:50					
		y service staff were					
		to client #3's feeding					
	_	client's return to the day					
		. When asked if the day					
		been given risk plans					
		ent of the peg tube, staff					
	•	y had not received any					
	risk plans from t	•					
	l lisk plans from t	ne group nome.					
	Interview with the	he Nurse Manager (NM)					
		00 PM indicated she was					
	not sure if staff v	were monitoring for					
		IM stated "I have not					
	been in the group	p home." When asked					
	what staff should	d do during a tube					
		stated "I don't know."					
	Interview with the	he Nurse Manager (NM)					
	and the Director	of Health Care Services					
	(DHCS), LPN #	1, SC #1 and the Program					
	Coordinator (PC	(a) on 4/17/13 at 3:50 PM					
	indicated client #	#3 had been on Hospice					
	in the past. The	NM indicated client #3					
	was on Hospice	for Failure to Thrive, but					
	had since been re	emoved from Hospice					
	Services. LPN #	#1 indicated client #3 was					
	last hospitalized	for Aspiration					

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Event ID: W6DF11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G559	B. WING		05/03/2013
NAME OF I	PROVIDER OR SUPPLIER)	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	. KOVIDEK OK SUPPLIER	•	2901 B	EVERLY DR	
ARC OF	NORTHWEST IND	IANA INC, THE	GARY,	IN 46408	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		returned to the group			
		tics. The NM indicated			
	client #3's brother/guardian did not want				
	_	he feeding tube. LPN #1			
		#3 received a Peg tube			
		ailed a cookie swallow			
		d not know if the client			
	had a history of	pneumonia/aspiration.			
	When asked if fa	acility staff should be			
	monitoring for r	esiduals, LPN #1 stated			
	"Yes." LPN #1	stated the residual would			
	be "cream color"	' when checking the			
	residuals and the	e client still had food in			
	her stomach. LI	PN #1 indicated facility			
	staff should repo	ort residuals over 60 ml.			
	LPN #1 and the	DHCS stated using a			
	wash cloth to cle	ean the opening of the peg			
	tube would be "	harsh." LPN #1 indicated			
	the facility staff	received a memo to			
	change the gauz	e dressing daily. When			
		lity staff first notified			
		3 did not feel well, LPN			
		ure." The DHCS, NM			
		cated facility staff should			
		ne nurse of the PRNs			
		ed. LPN #1 and the NM			
	indicated facility	staff and the day			
	_	d been trained in regard			
		g tube. When asked if			
		l conducted competency			
	_	e staff understood and/or			
	_	rrectly, LPN #1 indicated			
		ning had been conducted			
		y. LPN #1 indicated no			
	,, itili Stall // I Olli				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/03	
	PROVIDER OR SUPPLIER		р. үүл	STREET A	ddress, city, state, zip code EVERLY DR N 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
IAU	competency train the other staff in day program. We been trained in repneumonia, LPN indicated the guiplace in regard to medications/feed specific in regard should clean the indicated client # plan for the Peg client #3 had a ri LPN #1 stated "I indicated client # in the past (2009 client #1's instruction what facility staff tube opening was the PC indicated with Dementia. PN #1 and the N did not have a ri The PC and SC met in regard to Interview with c 4/19/13 at 8:38 A was recently hos pneumonia and to tube for feeding, indicated he did	ning had been done with the group home and/or then asked if staff had egard to aspiration I #1 stated "No." LPN #1 delines/instructions in to how to administer I the client were not I to how facility staff peg tube site. LPN #1 #3 did not have a risk tube. When asked if sk plan for Dysphagia, believe so." The PC #3 had a Dysphagia plan). LPN #1 indicated ctions did not indicate If were to do if the peg s bleeding. The NM and client #3 was diagnosed L - M indicated client #3 sk plan for Dementia. indicated the IDT had not client #3's health needs. All indicated client #3 pitalized for aspiration the client received a peg Client #3's guardian not want client #3 to		IAG			DATE
		but was convinced by as needed. Client #3's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	identification number: 15G559	A. BUII	LDING	00	COMPL 05/03/	
		100008	B. WIN		PPPPG GWY GW	05/03/	2010
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE EVERLY DR		
ARC OF	NORTHWEST INC	DIANA INC, THE			IN 46408		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
IAG		"I wasn't going to do it.		IAG	,		DATE
	~	life. I don't see her					
	improving. I am going to get that thing						
		she passes cookie test."					
		rdian indicated client #3					
		talized in the past for					
	-	lient #3's guardian					
	indicated with t	_					
	hospitalization, they did not think client						
	#3 would survive as the client was on life						
	support with a	breathing tube.					
	Interview with the DHCS and LPN #1 on						
	4/19/13 at 1:35	PM indicated they did not					
		\$\frac{1}{2}\$ was assessed by a nurse					
		o the client's difficulty in					
		DHCS and LPN #1					
		sessment should have					
		l and documented in the					
		When asked if staff #6,					
		been trained in regard to					
	_	PN #1 indicated she had					
	no additional tr	raining documentation.					
	Interview with	administrative staff #1 on					
		PM indicated the facility					
		he allegation of neglect					
	1	nt) to the Bureau of					
	,	Disabilities Services.					
	_	staff #1 indicated					
		day program staff were					
	investigated and	• • •					
		staff #1 stated they					
		nvestigation to see "what					

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		15G559	B. WIN	G		05/03/	2013
	ROVIDER OR SUPPLIER			2901 BE	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	happened and ho	w."					
	reports, internal in Reports and/or in reviewed on 4/16 facility's reportal Reports and/or in the following: -8/12/12 at 3:45 clients, [client #3 small scrape on Internal scrape on In	reportable incident Incident/Accident (I/A) nvestigations were 6/13 at 2:29 PM. The ble incident reports, I/A nvestigations indicated AM, "Went to check on B] was on floor, has a ner right knee. Could myself. Waited until e in at 6 AM. Covered w under head." The I/A ff called the nurse, left a bhone and sent an e-mail. d to indicate any nd/supervisors were nd assist in getting the floor. The I/A indicated dinator did not review rt until 8/31/12. The I/A ility's nurse reviewed the n 8/17/12 at 3:17 PM. d the nurse documented followed." The facility's to report an allegation of to the administrator in 1 leaving the client on 45 AM to 6:00 AM. PM, "Received a call					
	message on her part of the I/A neglecter additional staff at called to come and client up off the the Service Coorthe incident report indicated the fact incident report of the I/A indicated "Risk plan was for nurse neglected to possible neglect regard to staff #1	ohone and sent an e-mail. It to indicate any Ind/supervisors were Ind assist in getting the Indicated dinator did not review Indica					
	-8/16/12 at 8:00	PM, "Received a call					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN	G		05/03/2013
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		2901 BE	EVERLY DR	
	NORTHWEST IND				IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE
		e staff stating that [client				
		n her chair rocking				
	herself as she normally does, and rocked					
	herself to sleep,	falling over sideways				
	receiving a red r	nark on her forehead.				
	Staff assisted [cl	ient #3] back to her				
	sitting position a	and checked her for any				
	injuries. No app	arent injuries were found				
		nall red area on forehead.				
	Staff put pillows	on her sides to prevent				
	her from leaning over too far again. This					
	was an isolated incident."					
	was an isolated i	nordent.				
	-The facility's 8/	16/12 I/A Report				
		#3 fell "head first" to the				
	floor.	75 Tell Head Hist to the				
	11001.					
	The facility's 8/2	21/12 follow-up report				
	_	re were no additional				
	iniuries incurred	from this incident, and				
	3	her forehead is healed.				
		ot fall back asleep after				
		e was not in a rocking				
		a regular arm chair.				
		tistic and rocks hard				
		whatever chair she is				
		whatever chair she is				
	seated in."					
	During the 4/16/	13 observation period				
	_	A and 7:30 PM at the				
	group home, clie					
		she arrived at the group				
		O 1				
		PM, staff #1 assisted				
	client #3 to stand	d and pivot to sit on the				

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G559	LDING	00	COMPL 05/03/	ETED
	PROVIDER OR SUPPLIER		2901 BE	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	couch with little client upright. S small stuffed ani Client #3's upper forward. No star living room to re Client #3 had a pillow to each si uneven. The pill support to sit up her head and uppuntil the stuffed to the floor. Clie lean to her right not in a safe sitti PM, the surveyo #3 should be lear couch, staff #1 rroom and physic straight. Staff # would lean to the During the 4/16/between 5:38 Angroup home, clie wheelchair for mot ambulate and During the 4/16/between 2:40 PM facility's owned remained in her	s was placed on the supports to keep the taff #1 also placed a mal in client #3's lap. body started leaning ff was present in the edirect the client to sit up. billow at her back and a de of her which was lows did not provide right. Client #3 sat with per body bent forward animal fell out of her lap ent #3 then started to side onto the pillow, stilling position. At 6:40 rasked staff #1 if client ming while sitting on the eturned to the living ally sat client #3 up I indicated client #3 e side and/or forward. 13 observation period M and 8:45 AM, at the ent #3 utilized a nobility. Client #3 did d/or use a gait belt. 13 observation period M and 4:20 PM, at the day program, client #3 wheelchair except to be 3 did not walk and/or				

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	OF CORRECTION OF CORRECTION 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 05/0	TE SURVEY PLETED 03/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 Bi	ADDRESS, CITY, STATE, ZIP CO EVERLY DR IN 46408	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	utilize a gait belt. Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's 3/13/13 physician's order indicated the client's doctor ordered "OT/PT (Occupational Therapy/Physical Therapy) eval (evaluation/ w/ (with) chair assessment Dx (diagnoses Down Syndrome, Dementia." Client #3's Cumulative Medical Record notes and/or chart did not indicate client #3's OT/PT evaluations had been completed and/or set up. Client #3's 3/7/12 Quarterly Nursing Review indicated client #3 utilized a wheelchair for mobility. Client #3's 8/16/12 General Risk Factors Assessment indicated in the area of Physical Management, client #3 was "Unable to walk without verbal or greater assistance for any part of the day." The assessment indicated client #3 required the use of a gait belt when walking, and required "2 staff on either side." The assessment indicated client #3 had "One or more falls in the past 12 months." The 8/16/12 assessment indicated client #3 spent 2 or more hours a day in her wheelchair.	TAG	DEFICIENCY		DATE

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	COM	TE SURVEY PLETED 03/2013
	ROVIDER OR SUPPLIER		STRE 2901	ET ADDRESS, CITY, STATE, ZII 1 BEVERLY DR RY, IN 46408	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	indicated the "Romaintain health number of falls Grand Mal seizur fall. Client also gait. Baseline: for long distance walking." The findicated "Staff" #3], at all times, Staff need to rendown whenever fast" Client #3's 8/12/risk plan indicate neglected to meet client #3's fall risa wheelchair for health has detering a wheelchair for health has detering to walk and talk. #1 stated client #4 Administrative so "had been sick for thrive." Administrative so the solution of the all the solution of the all the solution of the all the solution of the s	all prevention plan need to monitor [client when she is walking. nind [client #3] to slow she is walking to (sic) 12 ISP and/or 8/12 fall ed the client's IDT et, review and/or update sk plan as the client uses mobility as the client's orated. dministrative staff #1 on PM stated client #3 "used " Administrative staff #3 was "In decline." taff #1 stated client #3 or a long time. Failure to etrative staff #1 indicated dent was not immediately dministrator. C #1, the PC, LPN #1,				
	the DHCS and the	ne NM indicated client				

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Event ID: W6DF11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
		15G559	A. BUII B. WIN	LDING		05/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF				EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ICED TO THE APPROPRIATE	
TAG	ł	chair for ambulation. SC		TAG	DEFICIENCY)		DATE
		ff were trying "side by					
		, ,					
	side to stand" with client #3. The NM indicated client #3 had an order to see the						
		er chart. The NM					
		d not know if the					
		d been scheduled as					
		did not indicate the					
		been scheduled. SC #1,					
		CS and the NM did not					
	not know if client #3 had a fall risk plan.						
	The PC indicate	d client #3's fall risk plan					
	would need to be	e revised as it indicates					
	the client walks	and utilizes a gait belt.					
		licy and procedures were					
		6/13 at 11:45 AM. The					
	_ ·	2 reviewed policy entitled					
	1	lling Cases Of Neglect					
		cated "1. The Arc					
		na prohibits all abuse,					
		oitation of our clients. II.					
	allegations if ab						
		out clients per agency					
	-	lure. The Arc Northwest					
		et current regulatory					
		reporting all incidents.					
	-	ons of abuse, neglect,					
	1	xploitation will be					
		the Arc Northwest					
	1 .	gation process, while					
		dividual" The policy					
		"as failure to consider					

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE (A. BUILDING B. WING	00	COM	E SURVEY PLETED 13/2013
	PROVIDER OR SUPPLIER		2901	r address, city, state, zii BEVERLY DR ', IN 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	client and anticipal placing of a client poses a threat to being" The poses of neglect include to, depriving client	the safety or care of the pate and remedy the nt in a situation that his/her health and well policy indicated examples led, but were not limited ents of medical care and roviding and "adequate"				

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	
		15G559	B. WIN			05/03/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST INDI				IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000153	The facility must of mistreatment, rinjuries of unknow immediately to the officials in accord through establish. Based on intervice 2 of 3 allegations injuries of unknown facility failed to allegation of possibility failed to allegation of negrous administrator and allegation of negrous Disability, Aging Services (DDAR Developmental I 460 IAC 9-3-1 (I Protective Services for client #3. Findings include 1. The facility's reports, internal interviewed on 4/16 facility's 3/14/13 report indicated [client #3] came not looking well (sic) staff notifice (technician). The	ew and record review for sof neglect and/or own source reviewed, the immediately report an sible neglect to the d/or failed to report an elect to the Division of g and Rehabilitative (LS)/BDDS (Bureau of Disabilities Services) per (D) (5) and to Adult (D) (5) and to Adult (D) (12-10-3) error (1/4) investigations were (1/4) at 2:29 PM. The reportable incident (I/A) investigations were (1/4) investigations were (1/4) investigations were (1/4) investigations were (1/4) at 2:29 PM. The reportable incident (I/The staff noticed when in she was shaking and and looking right, the	W0	00153	The Behavioral Health Directo and/or Quality Systems Director will re-train Services Coordinate and Nurses on the procedure reporting injuries of unknown origin and allegations of abuse/neglect to the administrand BDDS by 5/31/13. To ensure future compliance, the Behavioral Health Director will review incident/accident report to ensure that a BDDS report to ensure that a BDDS report to ensure that a BDDS report of the administrator has been notified for all injuries of unknown originand allegations of abuse/negled in addition a team meeting will held for all clients that are hospitalized with in 24 hrs of discharge to review treatment/plans and staff training. An investigation will be completed all individuals whom are hospitalized for aspiration pneumonia. This investigation will not only review staffs action but all plans and treatments the had been in place to ensure the facility's planning or lack of planning did not lead to the hospitalization. If neglect is suspected it will be reported, preporting guidelines.	or tors for ator the as as d n ect. be risk	05/31/2013

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Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G559	B. WING	G		05/03/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· /	ediately called the					
		. The health tech tried					
] crushed Tylenol (fever)					
	with applesauce but she would not take it.						
	911 was called. The nurse took [client						
		e which was 103.8. The					
	nurse assessed [c	client #3] by checking her					
	lungs which was	(sic) clear and checking					
	her abdomen wh	ich was soft. The EMT's					
	(Emergency Med	dical Technicians) arrived					
	and took [client #3] to [name of						
	hospital]." The 3	3/14/13 reportable					
	incident report in	ndicated the facility did					
	not report it was	looking at neglect in					
	regard to client #						
	The facility's 3/1	4/13 Investigation Fact					
	Sheet Summary	and Conclusion indicated					
	"Allegation: Pos	ssible Neglect-Consumer					
		to Day Services and					
	_	ethargic. Res (residential)					
		at client was a little extra					
	_	y morning. Staff had to					
		ast 4 times during					
		morning staff got client					
		nop-client took morning					
		applesauce & took blood					
	pressure 106/62.	* *					
	_	t ate about 3/4 of					
		had to keep waking client					
		ast. Staff reported that					
	l .	y the previous nurse that					
		e good days & bad days					
	and some days w	vould seem a little extra					

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Event ID: W6DF11

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G559	A. BUI	LDING	00	COMPL 05/03/	
		100008	B. WIN			05/03/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	ANA INC, THE			EVERLY DR IN 46408		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		r picked client up and					
	1	that client did not eat all					
		Med driver stated, that					
		iceable behaviors.					
	During the past 3	3 days, Res staff					
	I	lient was alert & trying to					
		ay client was doing a lot					
	of sleeping and h	and to wake client up to					
	feed her. Wedne	esday client was feeding					
	self with her han	ds for breakfast. Staff					
	fed her dinner in	the evening. She ate a					
	lot of her dinner.	Midnight staff noted					
	that client did no	t wake up during the					
	night. Nurse did	not receive any phone					
	calls/pages in the	e last 72 hours. Client					
	did seem a little	more tired per staff the					
	morning of 3-14	-13 but this is not out of					
	the ordinary for	client. Re (resident) staff					
	was told by prev	ious nurse that this is to					
	be expected with	client. Med driver did					
	not notice any di	fferent behaviors from					
	client the mornir	ng of 3-14-13." The					
	3/14/13 investiga	ation indicated "The					
	_	true" The facility's					
	_	s indicated "No neglect					
		staff. Staff should return					
	•	tion not substantiated"					
	Interview with a	dministrative staff #1 on					
	4/19/13 at 3:00 F	PM indicated the facility					
		e allegation of neglect					
	_	t) to the Bureau of					
	`	Disabilities Services.					
	, , , , , , , , , , , , , , , , , , ,						

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Event ID: W6DF11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILLAN	OI CORRECTION	15G559		LDING	00	05/03/	
		100000	B. WIN		DDDDGG GYMY GW :	03/03/	2010
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC I)		DATE
	-	reportable incident					
	_	Incident/Accident (I/A)					
	•	ovestigations were 5/13 at 2:29 PM. The					
		ble incident report dated AM, indicated "Went to					
		[client #3] was on floor,					
		be on her right knee.					
		r up by myself. Waited					
	_	f came in at 6 AM.					
		put pillow under head."					
	_	d the staff called the					
		sage on her phone and					
		The I/A indicated the					
		eviewed the incident					
	-	2 at 3:17 PM. The					
	facility's nurse fa						
	_	sible neglect to the					
		regard to staff #11					
		t on the floor from 3:45					
	AM to 6:00 AM						
		dministrative staff #1 on					
		PM indicated the 8/12/12					
		immediately reported to					
	the administrator	ſ.					
	0.2.2()						
	9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 05/03/2013		
		15G559	B. WIN	G		05/03	/2013
	ROVIDER OR SUPPLIER			2901 BI	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
TAG W000157	483.420(d)(4) STAFF TREATMI If the alleged viola corrective action in Based on 1 of 3 a abuse and/or injureviewed, the fact appropriate corre- provide retraining allegation of neg Findings include The facility's reprinternal Incident, and/or investigat 4/16/13 at 2:29 Freportable incide and/or investigat following: -3/8/13 at 12:23 #3] has a cold and different today d stopped up." The section indicated has a cold and I on as a cold and I on a co	ENT OF CLIENTS ation is verified, appropriate must be taken. allegations of neglect, uries of unknown source cility failed to take active measures and/or g in regard to an lect involving client #3. : ortable incident reports, //Accident (I/A) Reports ions were reviewed on PM. The facility's ant reports, I/A reports ions indicated the PM, "Staff noticed [client d is breathing (sic) ue to her nose being e I/A "Action Taken" "It does seem that she did give her meds of ne) but it still seems that (sic). I (day service safety Technician) call e over and assess." The Health & Safety sed the client on 3/8/13 at alled the nurse on 3/8/13	W0	TAG 00157	Client #3 is discharged at th time. An investigation will be completed for all individuals whom are hospitalized for aspiration pneumonia. This investigation will not only restaffs actions, but all plans a treatments that had been in plus the cause of the hospitalization to ensure that facility's planning or lack of planning did not lead to the hospitalization. These plans be corrected as necessary in order to prevent future negles ituations. If neglect is suspit will be reported, per report guidelines.	view Ind place t the s will nectful ected	05/31/2013
	12:55 PM and ca						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G559	B. WIN	G		05/03/2	2013
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			2901 BE	EVERLY DR		
	NORTHWEST IND	·		GARY, I	N 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		lity's nurse assessed the					
	client.						
	2/14/12 UT1	CC 4: 1 1 F 1: 4					
		aff noticed when [client					
	_	was shaking and not					
	_	l looking right. the (sic)					
		health tech (technician).					
		took [client #3's]					
	*	ch was a high temp					
	, ,	nediately called the					
	residential nurse	. The health tech tried					
	giving [client #3] crushed Tylenol (fever)					
	with applesauce	but she would not take it.					
	911 was called.	The nurse took [client					
	#3's] temperatur	e which was 103.8. The					
	_ ^	client #3] by checking her					
	_	s (sic) clear and checking					
	_	nich was soft. The EMT's					
		dical Technicians) arrived					
	and took [client	· · · · · · · · · · · · · · · · · · ·					
	hospital]."	ms] to [nume of					
	nospitalj.						
	The facility's 3/1	4/13 I/A Report indicated					
	upon arrival to the	he day program, staff					
	noticed a "chang						
	1	es" with client #3.					
	The facility's 3/1	4/13 Investigation Fact					
	Sheet Summary	and Conclusion indicated					
	"Allegation: Pos	ssible Neglect-Consumer					
	_	to Day Services and					
		ethargic. Res (residential)					
		at client was a little extra					
	_	y morning. Staff had to					
	1	, , , , , , , , , , , , , , , , , , , ,	1				

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G559	B. WING		05/03/2013
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
ADO 05	NODELIMICATIVES	IANIA INIC. TUE		BEVERLY DR	
	NORTHWEST INDI	·		, IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
TAG			TAG	Dia relation (DATE
		ast 4 times during			
	breakfast. Res. morning staff got client ready for workshop-client took morning				
	1 *	applesauce & took blood			
	pressure 106/62.				
	_	t ate about 3/4 of			
		had to keep waking client			
		Tast. Staff reported that			
		y the previous nurse that			
		re good days & bad days			
		yould seem a little extra			
		er picked client up and			
		Sthat client did not eat all			
	1	Med driver stated, that			
		ticeable behaviors.			
	During the past 3				
		lient was alert & trying to			
	1	ay client was doing a lot			
		nad to wake client up to			
		esday client was feeding			
		ids for breakfast. Staff			
		the evening. She ate a			
		_			
		. Midnight staff noted of wake up during the			
		1 0			
		I not receive any phone e last 72 hours. Client			
		more tired per staff the			
	•	-13 but this is not out of			
	1	client. Re (resident) staff			
		rious nurse that this is to			
	-	n client. Med driver did			
		ifferent behaviors from			
		ng of 3-14-13." The			
	3/14/13 investiga	ation indicated "The			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G559	B. WING	;		05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY, I	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	allegation is not true" The facility's						
		s indicated "No neglect					
	' '	staff. Staff should return					
	to work. Allegat	tion not substantiated"					
	A 3/14/13 witness statement by staff #1						
		•					
	,	aff #1) had told the med lid not eat all her					
		at client #3 still had a					
		witness statement					
		1 filled out a daily log					
		t she (client #3) was still					
		with taking the Sudafed					
		sOn Monday [client #3]					
		ing to feed herselfOn					
	1	s doing a lot of sleeping.					
		r to feed herI was told					
	l -	had our house that					
		d have good days and bad					
	_	to be expected with her					
	illness."						
		1 20.40					
		ss statement by staff #3					
		ff worked the overnight					
		d on client #3 three					
		n 3/14/13. The witness					
		ted client #3 slept					
		t, and "I (staff #3)					
	noticed nothing	unusual"					
	A 2/14/12	ag atotomant with the war					
		ss statement with the van					
		he transported client #3					
	_	on 3/14/13. The van					
	driver indicated	"I was told that client did					

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		STRUCTION 00	CON	TE SURVEY MPLETED	
		15G559	B. WING			. 05/	03/2013
	PROVIDER OR SUPPLIER		29	01 BE\	dress, city, state, zip /ERLY DR I 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Health Technicia	or [staff #1]). No rior. 9:45 [Name of an] asked why did I bring asked why did I bring asked why did not eat					
	indicated client # when the client of 3/14/13. The winclient #3 was " cold" Staff #4 indicated "This wasn't breathing report on it. The	ss statement by staff #4 #3 did not "look right" came in to work on tness statement indicated shaking like she was I's witness statement s week I noticed she right. I did incident e nurse from main came en they returned her back					
	health techniciar client #3 as staff was shaking and statement indica 103.5 and she (tlimmediately call she 9:43 she going she would let [L. The witness state health tech then crushed Tylenol client #3 did not statement indical paged at 9:45 and	ss statement with the indicated she checked had complained client #3 cold. The witness ted the temperature was he health tech) ed LPN #1 who "saiding to a meeting (sic) & PN #2] know (sic)" ement indicated the went to give the client in applesauce which take. The witness ted she then had LPN #2 d told her "to come is [client #3] was real					

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Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN	G		05/03/2013
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					EVERLY DR	
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY, I	IN 46408	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	sick"					
		ss statement with				
	_	nator] (SC) #3 indicated				
	"Have not receiv	red any calls from group				
	home regarding	[client #3]. I did not				
	know she had a	cold until I received the				
	logs from nurse.	"				
	A 3/15/13 witnes	ss statement by staff #2				
	indicated "Wed	d (Wednesday) evening				
	[client #3] seem	to have a pretty decent				
		r, she was a little tired.				
		ning she sat up & before				
		ke 2 to 3 words. She was				
	_	ursday morning. Once				
	1 -	out of her room, she				
	_	ra tired. Staff gave gave				
		ther blood pressure. I				
		the reading exactly but I				
		was in the normal				
		itness statement by staff				
		revious nurse had told				
		ould "be tired off and				
	on."					
	A 2/15/12it	as statement by the Niege				
		ss statement by the Nurse				
		ndicated she had been				
	<u> </u>	2 on 3/14/13 indicating				
		having the shakes &				
	_	as going over to check				
		shortly after & said it was				
	· ·	rgic, unable to swallow				
	Tylenol. To call	911. I told her to do a				

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Event ID: W6DF11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE : COMPL		
11112 12111	or confidence.	15G559		LDING		05/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST IND	ANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	physical assessm	e before leaving to hosp					
	` ′	#2] later told me she					
	` * / -	gs x (times) 2 & they were					
		nurse cell phone & did					
		ealls the last 12 hours."					
	The facility's har	nd written undated					
	investigative not	es indicated "Res staff					
	knew she had a c	cold, giving					
	Sudafed-putting	on logs1 staff aware					
	client had been c	ongested earlier in week-					
	No neglect-possi	ble poor					
	communication.'	' The facility's 3/14/13					
	investigation/fac	t failed to include any					
	corrective measu	•					
		nunication. The facility's					
	_	o failed to address the					
	facility's nursing						
		or follow-up in regard to					
	the 3/8/13 daily	_					
		ent was having difficulty					
	_	acility's investigation also					
		and/or recommend any					
		res/retraining for the lack					
		acility staff to the nurse					
	in regard to PRN	usage.					
	Interview with a	dministrative staff #1 on					
		PM indicated residential					
		staff were investigated					
		Administrative staff #1					
	_	acted an investigation to					
	see "what happen	_					
	Tr						

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Event ID: W6DF11

Facility ID: 001073

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150550			A. BUILDING B. WING	A. BUILDING 00				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE			
	REGULATORY OR Administrative s	taff #1 did not indicate ned staff and/or put in		CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE COMPLETION DATE			

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Facility ID: 001073

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		A. BUILDING B. WING			COMPLETED 05/03/2013		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EVERLY DR		
ARC OF I	NORTHWEST INDI	ANA INC, THE			IN 46408		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	REGULATORY OR 483.430(a) QUALIFIED MEN PROFESSIONAL Each client's activ be integrated, coc a qualified mental Based on intervice 2 of 4 sampled cl facility's Service -Qualified Intelle Professional (QII guardian had give Support Plan for failed to monitor no monthly sumr completed from failed to monitor assessments, and identified needs for The QIDP failed implemented clie	TAL RETARDATION The treatment program must ordinated and monitored by retardation professional. The wand record review for the tients (#1 and #2), the Coordinator (SC) to trual Disability DP) failed to ensure the en consent for a Behavior client #2. The QIDP client #1's objectives as maries had been 19/12 to 2/13. The QIDP client #1 in regard to failed to address for clients #1 and #2. The consure facility staff tent #1's training lined in the client's	W0)	
	Findings include	:					
	for Client #2 indidiagnoses include to, mental retarda congenital blindred disorder, and dial Behavior Support	ed, but were not limited ation, Down Syndrome, ness in right eye, seizure					

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Event ID: W6DF11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLE	ETED
		15G559	B. WIN			05/03/2	2013
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2901 BE	EVERLY DR		
	NORTHWEST IND	ANA INC, THE			IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	hitting her head,	and picking her skin.					
	On 4/19/13 at 12	2:20 PM, Administrative					
	staff #2 was inte	rviewed and indicated the					
	facility had no d	ocumentation of guardian					
	-	nt #2's Behavior Support					
		ative staff #2 indicated it					
		olicy to secure guardian					
		ne Behavior Support Plan					
		• •					
	included restricti	ive practices.					
	2 The OIDD foi	led to re-assess client					
	-	to ensure an appropriate					
		•••					
		ss client #2 in regard to					
	declining mobili	ty. Please see W210.					
	3. The QIDP fai	led to obtain a					
	-	essment as ordered for					
	client #3. Please						
	Cheffi #3. 1 lease	2 SCC W 218.					
	4 The OIDP fai	led to assess client #1's					
	-	skills. Please see W220.					
	Communication	skins. Tiedse see W220.					
	5 The OIDP fai	led to include Physical					
	Therapy recomn	•					
		ce Plan for client #2.					
	Please see W227	•					
	6 The OIDP fai	led to address client #1's					
	`	needs in regard to					
		•					
	dressing and toil	eting. Please see W242.					
	7 The OIDD foi	led to ensure facility staff					
		-					
	implemented clie	zni #1 S itaning	I				

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Event ID: W6DF11

Facility ID: 001073

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		15G559	A. BUII B. WIN	LDING		05/03/	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		formal and/or informal		IAG			DATE
	-						
	8. The QIDP fai objectives to detrobjectives were a W255. 9. The QIDP fai objectives to detregressed and/or QIDP also failed individual prograreflect situations regressing as rela#2. Please see W10. The QIDP fa#1's objectives to failed to make promonths. Please see W11. The QIDP fa#1's objectives to failed to make promonths. Please see W11. The QIDP fa#1's objectives to could be considered.	led to monitor client #1's ermine if the client's achieved. Please see led to monitor client #1's ermine if the client had lost skills acquired. The let to revise a client's am plans as necessary to in which the client is ated to mobility for client w256. miled to monitor client to determine if the client rogress after three					

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Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MI A. BUII		00	(X3) DATE (COMPL 05/03/	ETED	
		15G559	B. WIN	G		05/03/	2013
	PROVIDER OR SUPPLIER NORTHWEST INDI			2901 BE	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W000210	interdisciplinary to assessments or respectively to supplement the conducted prior to Based on observer record review for (#1 and #2), the client #1's wheel appropriate fit arregard to declining. Findings include 1. During the 4/periods between and from 5:10 Plandings include wheelchair for many wheelchair for many wheelchair had rest wheelchair. A had across the client's head rest wheelchair. A had across the client's arm pastrap velcroed/faclient. Client #1 knee/leg straps/b them in position by velcro. Staff into the special straps/straps	ter admission, the eam must perform accurate eassessments as needed e preliminary evaluation of admission. ation, interview and rr 2 of 2 sampled clients facility failed to re-assess chair to ensure an end to re-assess client #2 in eng mobility. 16/13 observation 5:38 AM and 8:45 AM ent #1 utilized a custom enablity. Client #1's drest was approximately enthe client's head as the ed against the back of the orizontal strap went es chest and under/near entits. Client #1's chest estend to the side of the enthe en	WO	00210	This client will have a wheelchair/PT evaluation completed by 5/31/13 To ensure future compliance, IDT will review all PT/OT, audiological, nutritional, health developmental and other assessments as they are received or at least annually to compare them to client goals a risk plans to ensure that all are of need are being addressed. The Behavioral Health Director designee will perform a randor audit of client files at least quarterly to ensure that emergical client needs are being addressed by the team.	n, o and eas or or m	05/31/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN			05/03/2013
NAME OF F			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L		2901 BE	EVERLY DR	
	NORTHWEST IND	<u> </u>			IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE	DATE
		od between 5:38 AM and				
	· · · · · · · · · · · · · · · · · · ·	#1 removed herself from				
		y pulling on the velcro				
	until it became le	oose and undone. The				
	special straps/bra	aces did not hold the				
	client's spastic ex	xtremities as the client				
	would move her	legs until the velcro				
	loosened and bed	came undone. Client #1's				
	foot straps becar	ne undone as well and the				
	client had her fee	et off the foot rests. At				
	one point during	the observation period,				
		ned to the side in her				
		one foot up in the seat of				
		nd the other leg/foot				
	leaning to the sig					
	leaning to the sic					
	Client #1's recor	d was reviewed on				
	4/18/13 at 4:00 I	PM. Client #1's 9/19/12				
		ort Plan and/or record did				
		nt #1 had a wheelchair				
		sure proper fitting.				
	dssessment to en	sare proper ritting.				
	On 4/23/13 at 2:	59 PM, the facility				
		5/12 Delivery Ticket for a				
	1 *	lient #1. The delivery				
		client #1 received her				
		wheelchair on 10/16/12				
	which cost \$5,66					
	· · · · · · · · · · · · · · · · · · ·					
		#1's wheelchair included a				
	"knee blocker"/k	nee straps/brace.				
	Interview with s	taff #1 and #2 on 4/16/13				
	at 4:20 PM indic	eated client #1's chest				
	strap/harness did	I not fit the client				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN	IG		05/03/2013
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE	
400.05	NODEL WATER IND	IANIA INIO THE			EVERLY DR	
	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		#1 and #2 indicated the	+	1710		BATE
	1 1 2	erent chest harness on her				
		hair. Staff #2 stated the				
	client's current harness would fold up and did not look "comfortable" for the client					
	as it laid across the client's breast. Staff					
	#1 and #2 indicated client #1's head was					
	below the head rest on the wheelchair.					
	Interview with a	dministrative staff #2 on				
	4/18/13 at 3:40 PM indicated they were not sure if client #1's wheelchair fitted her					
	appropriately. A	Administrative staff #2 did				
	not locate and/or	r provide documentation				
	of a wheelchair	evaluation for the client to				
	ensure the client	was appropriately				
	evaluated.					
	2. During group	home observations on				
		6:15 AM and 8:45 AM,				
		oserved sitting only in her				
		ent #2 was observed in a				
	non-customized	wheelchair starting at				
		t #2 was wheeled up to a				
	table in the livin	g room and given her				
	picture book to l	ook through. At 6:47				
	AM, Client #2 w	vas observed sleeping in				
	her wheelchair.	At 6:54 AM, Client #2				
	was interacting v	with her book again and				
	then fell asleep t	until woken up by Service				
	Coordinator #1 f	for medication at 7:08				
	AM. At 7:42 Al	M, Client #2 was brought				
	to the kitchen tal	ble for breakfast and				
	proceeded to eat	breakfast while sitting in				

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Event ID: W6DF11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	ETED
		15G559	B. WIN			05/03/2	2013
			D. 111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC. THE			IN 46408		
				ID		1	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110			-	1110			DITTE
		At 8:32 AM, Client #2					
	was prompted to help put her arm through her coat in preparation of traveling to day						
	service program						
	During day service program observation						
	on 4/16/13, betw	veen 3:13 PM to 4:13 PM,					
	at 3:13 PM, Clie	ent #2 was sitting in her					
	wheelchair being	•					
	· `	-					
	applesauce with a spoon by Staff #4. When snack was complete, Staff #4						
		\$2 over to a table. Client					
		I to remain in her					
		ighout the rest of day					
	service observat	ion.					
	On 4/18/13 at 1:	00 PM, a record review					
	for Client #2 ind	licated Client #2's					
	diagnoses includ	led, but were not limited					
	to, mental retard	ation, Down Syndrome,					
		ness in right eye, seizure					
	disorder, and dia						
	and and						
	-An outnatient D	Physical Therapy (PT)					
	_	4/1/08 indicated Client					
		ithout assistive devices					
		ith a steady gait. The					
		ated Client #2's standing					
	and walking dyn	namic balance were tested					
	and graded "goo	d." Client #2 was not at					
	risk for falls.						
	-A Physical The	rapy (PT) evaluation					
		dicated Client #2 had					
	dated 0/10/10 III	areated Chefft #2 flau					

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Event ID: W6DF11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559			LDING	NSTRUCTION 00	(X3) DATE COMPI 05/03	LETED	
	PROVIDER OR SUPPLIER		•	2901 BE	DDRESS, CITY, STATE, ZIP CODE EVERLY DR N 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	tendency to sit "evaluation indicated minimum assistated sitting position to moderate assistated. The evaluation in instructed on the transfer and gives Client #2. The extra to perform reevaluated 11/22/10 in not walk alone of but had effective except her left an indicated "hower months has refus standing, transfer can stand without of the Developmed 3/30/11 indicated balance but could down stairs by a assessment indicated use of a left arm. -The Medical Refuse the Medical Refuse the Indicated wheelchair assessments.	atted Client #2 required ance to transfer from a constanding position and ance to transfer to bed. Indicated staff were appropriate way to en home exercises for evaluation recommended aluation if needed. Belopmental Assessment andicated Client #2 could be a go down stairs alone a use of all her limbs arm. The assessment ever, the last several					

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Event ID: W6DF11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN			05/03/2013
NAME OF F	DROVADED OD GLIDDI IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	<u>C</u>		2901 BE	EVERLY DR	
	NORTHWEST IND	·		GARY,	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ed for Client #2 for				
	generalized muse	cle atrophy.				
	- A Human Right	ts Committee - Survey of				
	1	t #2 dated 2/28/11				
	indicated a revie					
	"wheelchair for i	mobility" for Client #2.				
	-The Developme	ental Assessment dated				
	-	d Client #2 had poor body				
	balance and was	unable to walk alone or				
	walk down stairs	s by herself. The				
		eated Client #2 had				
		ner right arm only.				
		ioi right urin omy.				
	-Client #2's Gen	eral Risk Factors				
	Assessment date	d 9/26/12 indicated				
	Client #2 was "u	nable to walk alone,"				
		gait belt, required				
	_	ce for transfers, had one				
	1	past 12 months, one or				
	_	n past 3 years, and spent 2				
		er day in a wheelchair.				
	nours or more pe	n day in a wheelenan.				
	-Client #2's Indiv	vidual Service Plan (ISP)				
		dicated the following				
		cation with pictures,				
	_	y, identifying needs, table				
		medications, washing				
	"	eds, and brushing teeth.				
	idee, toneting ne	ous, and ordening toom.				
	-The Developme	ental Assessment dated				
	1/27/13 indicated	d Client #2 could stand				
	without support	for 5 minutes, had				

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G559	A. BUILDING B. WING	00	COMPI 05/03	ETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 BI	ADDRESS, CITY, STATE, ZIP CO EVERLY DR IN 46408	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	effective use of her right arm only but was beginning to help with transfers and walking from the wheelchair to the dining room table.				
	During an interview on 4/18/13 at 2:21 PM, the Nurse Manager indicated Client #2's ISP did not include the PT recommended exercises or any range of motion exercises. Administrative staff #2 indicated Client #2's wheelchair assessment could not be located from 12/30/10. No documentation could be located indicating Client #2 had an updated PT evaluation since the 6/16/2010 PT evaluation. 9-3-4(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		15G559	B. WIN	G		05/03	3/2013
	PROVIDER OR SUPPLIER			2901 BI	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W000218	483.440(c)(3)(v) INDIVIDUAL PRO The comprehensimust include sense Based on observing record review for the facility failed assessment as or Findings include The facility's reginternal Incident and/or investigate 4/16/13 at 2:29 Freportable incide and/or investigate following: -8/12/12 at 3:45 clients, [client #3 small scrape on 19 get her up by my staff came in at 60 put pillow under the staff called the on her phone and -8/16/12 at 8:00 from group hom #3] was sitting in as she normally to sleep, falling or red mark on her	DGRAM PLAN ive functional assessment sorimotor development. ation, interview and r 1 additional client (#3), d to obtain a sensorimotor dered. State of the following the	WO	00218	This client will have a wheelchair/PT evaluation completed by 5/31/13 To ensure future complian IDT will review all PT/OT, audiological, nutritional, he developmental and other assessments as they are received or at least annua compare them to client gorisk plans to ensure that all of need are being address. The Behavioral Health Direction designee will perform a rail audit of client files at least quarterly to ensure that en client needs are being add by the team.	ealth, lly to als and ll areas ed. ector or ndom	05/31/2013

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI	PLE CON	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	15G559	A. BUILDIN	G .	00	05/03/	
		100000	B. WING	0.DDM 1.1		00/00/	2010
NAME OF F	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			N 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	G	DEFICIENCI)		DATE
		any injuries. No apparent					
	injuries were found other than the small red area on forehead. Staff put pillows on her sides to prevent her from leaning over						
	_	ent her from leaning over					
	too far again"						
	-The facility's 8/16/12 I/A Report						
indicated client #3 fell "head first" to the							
floor.							
	11001.						
	The facility's 8/2	21/12 follow-up report					
indicated "There were no additional							
		from this incident, and					
	l *	her forehead is healed.					
		ot fall back asleep after					
	-	e was not in a rocking					
		a regular arm chair.					
		tistic and rocks hard front					
	-	ver chair she is seated					
	in."						
	During the 4/16/	13 observation period					
	between 5:10 PN	A and 7:30 PM at the					
	group home, clie	ent #3 was in a wheelchair					
	when she arrived	l at the group home. At					
	6:25 PM, staff #	1 assisted client #3 to					
	stand and pivot t	o sit on the couch. Client					
	#3 was placed or	n the couch with little					
	supports to keep	the client upright. Staff					
	#1 also placed a	small stuffed animal in					
	client #3's lap. (Client #3's upper body					
	started leaning for	orward. No staff was					
	present in the liv	ring room to redirect the					
	client to sit up.	Client #3 had a pillow at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G559	B. WING	G		05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	illow to each side of her					
		en. The pillows did not					
	provide support to sit upright. Client #3						
		l and upper body bent					
		stuffed animal fell out of					
	^	or. Client #3 then started					
	to lean to her rig	ht side onto the pillow,					
	still not in a safe	sitting position. At 6:40					
	PM, the surveyor	r asked staff #1 if client					
	#3 should be lear	ning while sitting on the					
	couch, staff #1 re	eturned to the living room					
	and physically sa	at client #3 up straight.					
	Staff #1 indicate	d client #3 would lean to					
	the side and/or for	orward.					
	During the 4/16/	13 observation period					
	_ ~	M and 8:45 AM, at the					
	group home, clie	*					
		nobility. Client #3 did not					
	ambulate and/or	•					
	umounte una, or	ase a gair seit.					
	During the 4/16/	13 observation period					
	_ ~	A and 4:20 PM, at the					
		day program, client #3					
	_	wheelchair except to be					
		3 did not walk and/or					
	utilize a gait belt						
	Client #2's recor	d was reviewed on					
		AM. Client #3's 3/13/13					
	1 * *	r indicated the client's					
		OT/PT (Occupational					
	Therapy/Physica						
	(evaluation/w/(with) chair assessment					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM - 05/0	TE SURVEY TPLETED 03/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 BI	ADDRESS, CITY, STATE, ZIP CO EVERLY DR IN 46408)DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Dx (diagnoses Down Syndrome, Dementia."				
	Client #3's Cumulative Medical Record notes and/or chart did not indicate client #3's OT/PT evaluations had not been completed and/or set up.				
	Interview with administrative staff #1 on 4/19/13 at 3:00 PM stated client #3 "used to walk and talk." Administrative staff #1 stated client #3 was "In decline." Administrative staff #1 indicated client #3 "had been sick for a long time.				
	Interview with SC #1, the PC, LPN #1, the DHCS and the NM indicated client #3 used a wheelchair for ambulation. SC #1 stated the staff were trying "side by side to stand" with client #3. The NM indicated client #3 had an order to see the OT and PT in her chart. The NM indicated she did not know if the appointments had been scheduled as client #3's chart did not indicate the evaluations had been scheduled. 9-3-4(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
		15G559	A. BUILDING B. WING			05/03/2013	
	PROVIDER OR SUPPLIER		p. why	2901 B	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W000220	483.440(c)(3)(v) INDIVIDUAL PRO The comprehensi must include specific development. Based on observing record review for (#1), the facility client's community client's community client's community findings included buring the 4/16/between 5:38 AM 5:10 PM to 7:30 client #1 was not communication in speak. Facility sany communication in speak. Facility sany communication is a client and/or proto assist client #1 wants and needs Client #1's recort 4/18/13 at 4:00 Fundividual Supports and indicated following object	DGRAM PLAN ive functional assessment ech and language ation, interview and r 1 of 2 sampled clients failed to assess the ication skills. 13 observation periods M and 8:45 AM and from PM, at the group home, n-verbal in in that the client did not staff did not implement ion training with the vide any assistive devices I to communicate her d was reviewed on PM. Client #1's 9/19/12 ort Plan (ISP) and/or client #1 had the ives: Il continue to learn to	Wo	00220	This client will have a speech evaluation completed by 5/31 To ensure future compliance. IDT will review all PT/OT, audiological, nutritional, healt developmental and other assessments as they are received or at least annually compare them to client goals risk plans to ensure that all a of need are being addressed The Behavioral Health Direct designee will perform a rando audit of client files at least quarterly to ensure that emer client needs are being address by the team.	/13 The th, to and reas or o	05/31/2013
	#1] will reach fo	choice of 2 items, [client r the one she wants." 12 ISP and/or record did					

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Facility ID: 001073

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	OF CORRECTION OF CORRECTION 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	TE SURVEY MPLETED 03/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 BI	ADDRESS, CITY, STATE, ZI EVERLY DR IN 46408	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE (EFERENCED TO THE APPROPRIATE DEFICIENCY)	
	not indicate client #1's communication skills had been assessed. Client #1's ISP and/or record did not indicate the above mentioned objectives were recommended to assist the client to communicate her basic wants and needs.				
	Interview with Service Coordinator (SC) #1 and administrative staff #1 on 4/19/13 at 5:00 PM indicated client #1 was non-verbal in communication. SC #1 indicated the above 2 mentioned training objectives were client #1's communication training objectives. When asked if client #1 had a recent speech/communication assessment, administrative staff #1 stated "Not one in 2 years." Administrative staff #1 could not locate a communication assessment for client #1.				
	9-3-4(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPL	ETED
		15G559	A. BUII B. WIN			05/03/2013	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000227	483.440(c)(4) INDIVIDUAL PRO The individual pro specific objectives client's needs, as comprehensive a paragraph (c)(3) of Based on observer record review, the include Physical recommendation Service Plan for (Client #2). Findings include During group hoto 4/16/13 between Client #2 was obton-customized 6:32 AM. Client table in the living picture book to be AM, Client #2 we her wheelchair. was interacting we then fell asleep to Coordinator #1 fell AM. At 7:42 AM to the kitchen table proceeded to eat her wheelchair.	OGRAM PLAN ogram plan states the s necessary to meet the identified by the ssessment required by of this section. ation, interview, and he facility failed to Therapy s in the Individual 1 of 4 sampled clients	WO	00227	The Service Coordinator and Individual Program Coordinator will review all ISPs to ensure the list and address through plann or programming all risks, PT/C needs, speech needs, dietary needs, and behavioral needs. The ISP will list all adaptive equipment for the clients and who be made available to all staff working with that client by 5/3/1. To ensure future compliance, the Behavioral Health Director will audit IPP files following any change in client condition to ensure that the appropriate measures have been added to the ISP for three months and the periodically thereafter.	ney ing DT will I/13 the	05/31/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G559	B. WING		05/03/2013
NAME OF I	PROVIDER OR SUPPLIEI		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				EVERLY DR	
ARC OF	NORTHWEST IND	IANA INC, THE	GARY,	IN 46408	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	her coat in prepa	aration of traveling to day			
	service program.				
	During day serv	ice program observation			
	on 4/16/13 betw	een 3:13 PM to 4:13 PM,			
	at 3:13 PM, Clie	ent #2 was sitting in her			
	wheelchair being	g fed a snack of			
	applesauce with	a spoon by Staff #4.			
		s complete, Staff #4			
		#2 over to a table. Client			
	#2 was observed to remain in her				
	wheelchair throughout the day service				
	observation.	agnout the day service			
	observation.				
	On 4/18/13 at 1:	00 PM, a record review			
		licated client #2's			
	_	led, but were not limited			
		lation, Down Syndrome,			
	_	ness in right eye, seizure			
	disorder, and dia	abetes.			
		al : 1 ml (pm)			
	_	Physical Therapy (PT)			
		1 4/1/08 indicated Client			
		ithout assistive devices			
		ith a steady gait. The			
		ated Client #2's standing			
	and walking dyr	namic balance were tested			
	and graded "goo	d." Client #2 was not at			
	risk for fallsA	Physical Therapy (PT)			
	evaluation dated	6/16/10 indicated Client			
	#2 had standing	tolerance for 5 seconds			
	with a tendency	to sit "suddenly." The			
	1	ated Client #2 required			
		ance to transfer from a			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE (COMPL		
		15G559	A. BUI B. WIN	LDING		05/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		o a standing position and					
		nce to transfer to bed.					
		ndicated staff were					
		appropriate way to					
	1	n home exercises for					
		valuation recommended					
	_	luation if needed. The					
		commended 6 exercises					
twice a day for Client #2 which included							
	_	Arm Chair Push, Sitting					
Heel Rise, Sitting Toe Raise, Long Arc							
	Quads, Straight Leg Raises, and Bridging.						
	-Client #2's Developmental Assessment						
	dated 11/22/10 in	ndicated Client #2 could					
	not walk alone o	r go down stairs alone					
	but had effective	use of all her limbs					
	except her left ar	m. The assessment					
	indicated "hower	ver, the last several					
	months has refus	sed to help when					
	standing, transfe	rring, or toileting. She					
	can stand withou	at support for 5 minutes."					
	_	ental Assessment dated					
		d Client #2 had poor body					
		d walk alone and walk					
	1	Iternating feet. The					
		ated Client #2 had					
		all her limbs except her					
	left arm.						
	-The Medical Re	eview Worksheet dated					
	12/5/11 indicated	d Client #2 had a					
	wheelchair asses	sment on 12/30/10. The					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G559	B. WIN	G		05/03/2013
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
400.05	NODEL WATER IND	IANIA INIO TUE			EVERLY DR	
	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL CLSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		ated a manual wheelchair				D.III
		led for Client #2 for				
	generalized muscle atrophy.					
	-A Human Righ	ts Committee - Survey of				
		t #2 dated 2/28/11				
	indicated a revie					
		mobility" for Client #2.				
		•				
	-The Developmental Assessment dated 2/12/12 indicated Client #2 had poor body balance and was unable to walk alone or					
	walk down stairs	s by herself. The				
	assessment indic	cated Client #2 had				
	effective use of	her right arm only.				
	Client #2's Con	eral Risk Factors				
		ed 9/26/12 indicated				
		inable to walk alone,"				
		gait belt, required physical				
		ansfers, had one or more				
		nonths, one or more				
	-	3 years, and spent 2				
	_	er day in a wheelchair.				
	I more p	<i>j</i> 				
	-Client #2's Indi	vidual Service Plan (ISP)				
		dicated the following				
		cation with pictures,				
	_	y, identifying needs, table				
		medications, washing				
		eeds, and brushing teeth.				
	_	ental Assessment dated				
	1/2//13 indicate	d Client #2 could stand				

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		A. BUILDING B. WING	00	COMPLETED 05/03/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	without support for 5 minutes, had effective use of her right arm only but was beginning to help with transfers and walking from the wheelchair to the dining room table. During an interview on 4/18/13 at 2:21 PM, the Nurse Manager indicated Client #2's ISP did not include the PT recommended exercises or any range of motion exercises. 9-3-4(a)					

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE C A. BUILDING B. WING	OO OOSTRUCTION	(X3) DATE SURVEY COMPLETED 05/03/2013	
	ROVIDER OR SUPPLIER NORTHWEST INDI SUMMARY S'		STREET 2901 E	ADDRESS, CITY, STATE, ZIP CODE BEVERLY DR , IN 46408	(X5)
PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION
W000242	for those clients of personal skills est independence (in toilet training, per hygiene, self-feed grooming, and coneeds), until it hat the client is devel acquiring them. Based on observer record review for (#1), the client's (ISP) failed to actidentified basic of the desired dressing and toil with the final part of the first personal form of the first personal form of the f	ogram plan must include, who lack them, training in sential for privacy and cluding, but not limited to, sonal hygiene, dental ding, bathing, dressing, mmunication of basic is been demonstrated that opmentally incapable of ation, interview and in 1 of 2 sampled clients. Individual Support Plan lidress the client's needs in regard to eting.	W000242	The Service Coordinator will review all client goals for this home to assess if goals addressues including, but not limit to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressin grooming, and communicatio basic needs. If current programming is deemed ineffective, it will be revised/modified with IDT/guardian approval or the individual will be evaluated to if they are developmentally incapable of acquiring the ski and the goal will be discontin by 5/31/13. To ensure future compliance, IDT will review audiological, nutritional, health, developmentally and other assessments as the are received, after any signification change in client condition, or least annually to compare the client goals and risk plans to ensure that all areas of need being addressed. The Behav Health Director or designee visiting the same and the same a	g, n of see Il ued The ental ey cant at em to are vioral

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		A. BUILDING B. WING A. BUILDING B. WING A. BUILDING B. WING B. WING B. WING B. WING B. WING			ETED		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			ANA INC, THE	•	2901 BE	EVERLY DR		
PM stated client #1 was "total care " monitor for completion by	PREFIX ((EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
Staff #1 indicated client #1 required total staff assistance in regard to bathing, dressing, toileting and tooth brushing. Staff #1 indicated client #1 did not have any training in place in regard to toileting and dressing. Interview with Service Coordinator #1 and administrative staff #1 on 4/19/13 at 5:00 PM indicated client #1 did not have any training in place which addressed the client's basic needs of dressing and toileting. 9-3-4(a)	PM Staf staf dres Staf any and Inte and 5:00 any clies toile	M stated client # aff #1 indicated aff assistance in essing, toileting aff #1 indicated by training in pla ad dressing. terview with Se ad administrativ 00 PM indicate by training in pla ient's basic need ileting.	#1 was "total care." I client #1 required total a regard to bathing, g and tooth brushing. I client #1 did not have ace in regard to toileting ervice Coordinator #1 re staff #1 on 4/19/13 at d client #1 did not have ace which addressed the		TAG	monitor for completion by performing an audit on each fil by 5/30/13. A random audit of client files will occur at least quarterly to ensure that emerg client needs are being address	le :	DATE

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/03/2013	
	ROVIDER OR SUPPLIER		2901	T ADDRESS, CITY, STATE, ZIP CODE BEVERLY DR Y, IN 46408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
W000249	formulated a clier each client must be treatment prograr interventions and number and frequencial achievement of the individual program achievement for (#1), the facility client's training of and/or informal of and/or informal of and/or informal of and/or informal of the individual program achievement in the individual program achievement in the client and/or to plus the client. Clientitem and/or drophanded. During staff #1 wiped of she ate without experience with the above mention client #1 was not communication in the individual program and in the individual program achievement in the individu	terdisciplinary team has the individual program plan, receive a continuous active in consisting of needed services in sufficient tency to support the te objectives identified in gram plan. The individual program plan in the objectives when formal topportunities existed. The individual program plan in the objectives when formal topportunities existed. The individual program plan in the objectives when formal topportunities existed. The individual program plan in the objectives when formal topportunities existed. The individual program plan in the objectives and the group home, the individual program plan in the objectives when formal topportunities existed. The individual program plan in the objectives in sufficient without an objective in the objective in the objectives when formal to be handed an item to object without an	W000249	The Service Coordinator will review all client goals for this home to assess if goals addre issues including, but not limite to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing grooming, and communication basic needs. If current programming is deemed ineffective, it will be revised/modified with IDT/guardian approval or the individual will be evaluated to if they are developmentally incapable of acquiring the ski and the goal will be disconting by 5/31/13. Staff will be trains on implementing these goals 5/31/13 it will be documented return demonstration will occur needed. To ensure future compliance, The IDT will review audiological, nutritional, healt developmental and other assessments as they are received, after any significant change in client condition, or least annually to compare the client goals and risk plans to ensure that all areas of need being addressed. The Behavent is the same and the same and the client goals and risk plans to ensure that all areas of need being addressed. The Behavent is the same and th	see II ued ed by and ur as ew h, at em to are

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURV	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETEI	D
		15G559	B. WIN			05/03/201	3
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L.					
400.05	NODEL IMPO	IANIA INO. TUE			EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		CO	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	provided and/or offered to the client.				Health Director or designee wi	II]	
	provided und or ordered to the ordered.				monitor for completion by		
	Client #1's recor	d was reviewed on			performing an audit on each fil		
					by 5/30/13. A random audit of		
		PM. Client #1's 9/19/12			client files will occur at least		
		ort Plan (ISP) indicated			quarterly to ensure that emerg		
	client #1 had the	following objectives:			client needs are being address		
					by the team. 5/30/13 The Servi Coordinator will review all clier		
	-Respond to her	name			goals for this home to assess i		
					goals address issues including		
	"XV/le au aireau a	alanian af 2 itama [aliant			but not limited to, toilet training		
-"When given a choice of 2 items, [client				personal hygiene, dental hygie			
#1] will reach for the one she wants"				self-feeding, bathing, dressing			
				grooming, and communication			
	-When her name is called while she is				basic needs. If current		
	involved in an ac	ctivity, [client #1] will			programming is deemed		
	cease the activity				ineffective, it will be		
	cease the activity	y			revised/modified with		
	****				IDT/guardian approval or the		
	-Wipe her spot a	t the table after dinner			individual will be evaluated to	see	
					if they are developmentally		
	-"Before medica	tion is administered,			incapable of acquiring the skill and the goal will be discontinu	ad	
	[client #1] will re	espond correctly (reach			by 5/31/13. Staff will be traine		
	for medications)	•			on implementing these goals b		
	101 1110 410 4010 110)	•••			5/31/13 it will be documented a	-	
	Wash han faas				return demonstration will occu	as	
	-Wash her face				needed. Monitoring will occur	on	
					site as training opportunities a	re	
	Facility staff dur	ring the 4/16/13			offered. To ensure future		
	observation perio	ods did not implement			compliance, The IDT will revie		
	client #1's above	mentioned ISP goals			audiological, nutritional, health	,	
		l/or informal training			developmental and other		
	opportunities exi	•			assessments as they are received, after any significant		
	opportunities exi	isica.			change in client condition, or a	_t	
		` '					
	#1 on 4/19/13 at	t 5:00 PM indicated				re	
	facility staff show	uld provide			being addressed. The Behavio		
	<u>-</u>	-			Health Director or designee wi		
	#1 on 4/19/13 at facility staff show					re oral	

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Facility ID: 001073

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		A. BUILDING B. WING	00	COMPLETED 05/03/2013	
	ROVIDER OR SUPPLIER	IANA INC, THE	2901 B	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	9-3-4(a)			monitor for completion by performing an audit on each fi by 5/30/13. A random audit or client files will occur at least quarterly to ensure that emergical client needs are being address by the team.	le f ging

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Event ID: W6DF11

Facility ID: 001073

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	ETED
		15G559	B. WIN			05/03/2	2013
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .			EVERLY DR		
APC OF	NORTHWEST INDI	IANA INC. THE			IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000255	483.440(f)(1)(i) PROGRAM MON The individual pro reviewed at least retardation profes necessary, includ situations in which successfully compobjectives identifing program plan. Based on intervior 1 of 2 sampled contellectual Disar (QIDP) failed to objectives to determine the objectives were as Findings include Client #1's record 4/17/13 at 11:41 Individual Support the client had the - "[Client #1] wirespond to her na 2012." -"When given a content with the last 10 ses 2012." -When her name	pleted an objective or ed in the individual ew and record review for lients (#1), the Qualified bility Professional monitor client #1's ermine if the client's achieved. c: d was reviewed on AM. Client #1's 9/19/12 ort Plan (ISP) indicated e following objectives: ll continue to learn to ame by October 31, choice of 2 items, [client or the one she wants for 5 esions by October 31,	W0	TAG 00255	The Service Coordinator will monitor all clients' goal data are enter progress notes by 5/31/1 The Service Coordinator will the monitor goal data monthly and the IDT team will meet if any goals require modification. To ensure future compliance, the Behavioral Health Director will audit IPP files monthly to ensure that progress notes have been completed and client goals are being monitored for three mon and periodically thereafter if the skill is acquired.	nd 13. nen I the	DATE 05/31/2013
		ctivity, [client #1] will y of 0 of the last 0					

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Event ID: W6DF11

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING	00	COI	TE SURVEY MPLETED 03/2013
	PROVIDER OR SUPPLIES	<u> </u>	2901 BE	ADDRESS, CITY, STATE, ZIF	_	
	NORTHWEST IND	·		IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	sessions by Octo	ober 31, 2012."				
		Il touch a block with a 5 of the last 10 periods 2012."				
	her spot at the ta	ting, [client #1] will wipe ble after dinner for 12 of ons by October 31, 2012."				
	[client #1] will r	espond correctly with ace for 10 of the last 10 ober 31, 2012."				
	wash her face w	o do so, [client #1] will ith 90% independence for sessions by October 31,				
	monthly summa completed of the objectives to det	12 ISP indicated no ry reviews had been a above mentioned ermine if the client had es since the 9/19/12 ISP d.				
	#1/QIDP on 4/19 she had taken over new QIDP. SC data for 3/13 to a provide any add	Service Coordinator (SC) 9/13 at 5:00 PM indicated yer the group home as the #1 indicated she only had review. SC #1 did not itional monitoring and/or s of the client's objectives				

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G559	A. BUILDING B. WING	00	COMPLETED 05/03/2013
	ROVIDER OR SUPPLIER		2901 BI	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	to determine if the objectives.	ne client had met the ISP			
	9-3-4(a)				

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Facility ID: 001073

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/03/2013
		130339	B. WING		03/03/2013
	PROVIDER OR SUPPLIER		2901 E	ADDRESS, CITY, STATE, ZIP CODE BEVERLY DR , IN 46408	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
W000256	The individual profereviewed at least retardation profes necessary, include situations in which losing skills alread Based on interviewed 2 of 2 sampled of Qualified Inteller Professional (QI client #1's object client had regress acquired. The Quantified individual recessary to reflict in the regressional for client #2. Findings included 1. Client #1's read/17/13 at 11:41 Individual Support the client had the client had the client with respond to her national support of the client #1 with respond to her national support of the client #1 with respond to her national support of the client #1 with respond to her national support of the client #1 with respond to her national support of the client #1 with reach for the client for the c	ew and record review for lients (#1 and #2), the ctual Disability DP) failed to monitor cives to determine if the sed and/or lost skills IDP also failed to revise ual program plan as ect situations in which the ng as related to mobility	W000256	The Service Coordinator will review all client goals includin but not limited to, toilet training personal hygiene, dental hygiself-feeding, bathing, dressing grooming, and communication basic needs; for this home to assess if goals need to be accommodified, or discontinued by 5/31/13. The IDT will review audiologin utritional, health, development and other assessments as the are received or at least annual to compare them to client goand risk plans to ensure that areas of need are being addressed. The Behavioral Health Director or designee was perform a random audit of clifiles at least quarterly to ensuthat emerging client needs at being addressed by the team	ng, giene, gg, on of odded, cal, ental ey ally als all will ent ure

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Event ID: W6DF11

Facility ID: 001073

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULT A. BUILDIN B. WING		00	(X3) DATE COMPL 05/03/	ETED
	PROVIDER OR SUPPLIER		S ²	901 BE	DDRESS, CITY, STATE, ZIP CODE VERLY DR N 46408	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
IAU	-When her name involved in an accease the activity sessions by October 31, 2 -"[Client #1] will number on it for by October 31, 2 -"When done ear her spot at the tathe last 24 sessions by October 31, 2 -"Before medica [client #1] will responsible to the sessions by October 31, 2 -"When asked to wash her face will not be a sessions by October 31, 2 -"When asked to wash her face will not the last 12, 2012." Client #1's 9/19/monthly summar completed of the objectives to determent the objectives to determent with the sessions by October 31, 2 -"When asked to wash her face will not session by October 31, 2 -"When asked to wash her face will not session by October 31, 2 -"When asked to wash her face will not session by October 31, 2 -"When asked to wash her face will not session by October 31, 2 -"When of the last 12, 2012."	is called while she is ctivity, [client #1] will y of 0 of the last 0 ober 31, 2012." I touch a block with a 5 of the last 10 periods 012." ting, [client #1] will wipe ble after dinner for 12 of ons by October 31, 2012." tion is administered, espond correctly with ce for 10 of the last 10 ober 31, 2012." I do so, [client #1] will ith 90% independence for sessions by October 31, 12 ISP indicated no ry reviews had been above mentioned ermine if the client had es since the 9/19/12 ISP		AU			DATE
	#1/QIDP on 4/19	ervice Coordinator (SC) 9/13 at 5:00 PM indicated er the group home as the					

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Event ID: W6DF11

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G559	B. WIN	IG		05/03/	2013
NAME OF F	PROVIDER OR SUPPLIER	3	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	-	#1 indicated she only had					
		review. SC #1 did not					
	1 -	itional monitoring and/or					
	1	s of the client's objectives					
		he client had regressed					
	and/or lost acqui	ired skills.					
		t 1:00 PM, a record					
		t #2 indicated Client #2's					
		led, but were not limited					
		ation, Down Syndrome,					
	_	ness in right eye, seizure					
	disorder, and dia	abetes.					
	An autorations D	olessi sal Thansas (DT)					
	_	Physical Therapy (PT)					
		4/1/08 indicated Client					
		ithout assistive devices					
		rith a steady gait. The					
		ated Client #2's standing					
		namic balance was tested					
		d." Client #2 was not at					
	risk for falls.						
	A Dhygiaal Tha	rony (DT) avaluation					
	1	rapy (PT) evaluation dicated Client #2 had					
	_	ce for 5 seconds with a					
	tendency to sit "						
		ated Client #2 required					
		ance to transfer from a					
		o a standing position and					
		nce to transfer to bed.					
		ndicated staff were					
		e appropriate way to					
	transfer and give	en home exercises for					

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Event ID: W6DF11

Facility ID: 001073

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO	ONSTRUCTION 00	CON	TE SURVEY MPLETED 03/2013
		100000	B. WING	DDDDDD GV		00/2010
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP EVERLY DR	CODE	
ARC OF	NORTHWEST IND	ANA INC, THE	GARY,	IN 46408		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	DATE
		valuation recommended luation if needed.				
	dated 11/22/10 in not walk alone of but had effective except her left are indicated "hower months has refus standing, transfer can stand without -The Developme 3/30/11 indicated balance but could down stairs by a assessment indicated to the could be also	elopmental Assessment indicated Client #2 could it go down stairs alone is use of all her limbs it. The assessment iver, the last several ised to help when it support for 5 minutes." ental Assessment dated di Client #2 had poor body di walk alone and walk liternating feet. The isated Client #2 had all her limbs except her				
	-The Medical Re 12/5/11 indicated wheelchair asses worksheet indica	eview Worksheet dated d Client #2 had a sment on 12/30/10. The ated a manual wheelchair ed for Client #2 for				
	Rights for Client indicated a revie	es Committee - Survey of #2 dated 2/28/11				
	-The Developme	ental Assessment dated				

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Event ID: W6DF11

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	ISTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		15G559	B. WING			05/03/	2013
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIC. THE			VERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, II	N 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		d Client #2 had poor body					
		unable to walk alone or					
		s by herself. The					
		cated Client #2 had					
	effective use of	her right arm only.					
	-Client #2's Gen	eral Risk Factors					
	Assessment date	ed 9/26/12 indicated					
	Client #2 was "u	mable to walk alone",					
	required use of g	gait belt, required physical					
	assistance for tra	ansfers, had one or more					
	falls in past 12 n	nonths, one or more					
		3 years, and spent 2					
	_	er day in a wheelchair.					
	no uno or more p						
	-Client #2's Indi	vidual Service Plan (ISP)					
		dicated the following					
		cation with pictures,					
	~	y, identifying needs, table					
	•	medications, washing					
	0, 0	, ,					
	l face, tolleting ne	eeds, and brushing teeth.					
	TTI D 1	. 1					
		ental Assessment dated					
		d Client #2 could stand					
		for 5 minutes, had					
		her right arm only but was					
	beginning to hel	p with transfers and					
	walking from the	e wheelchair to the dining					
	room table.						
	During group ho	ome observations on					
		6:15 AM and 8:45 AM,					
	Client #2 was si						
		ent #2 was observed in a					
			I				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GAPY, IN 48408		OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE : COMPL	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (LACID DEFICENCY MUST BE PRICEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) IN on-customized wheelchair starting at 6:32 AM. Client #2 was wheeled up to a table in the living room and given her picture book to look through. At 6:47 AM, Client #2 was observed sleeping in her wheelchair. At 6:54 AM, Client #2 was brought to the kitchen table for breakfast and proceeded to eat breakfast while sitting in her wheelchair. At 8:32 AM, Client #2 was brought to the kitchen table for breakfast and proceeded to left put her arm through her coat in preparation of traveling to day service program. During day service program observation on 4/16/13 between 3:13 PM, to 4:13 PM, at 3:13 PM, Client #2 was sitting in her wheelchair being fed a snack of applesauce with a spoon by Staff #4. When snack was complete, Staff #4 wheeled Client #2 over to a table. Client #2 was observed to remain in her wheelchair throughout the day service observation. During an interview on 4/18/13 at 2:21								
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observation. During an interview on 4/18/13 at 2:21								
During an interview on 4/18/13 at 2:21			ghout the day service					
		observation.						
		During an interv	iew on 4/18/13 at 2:21					
1 1vi, the rvine vialiager indicated cheft		_						
#2's ISP had not been revised to include			_					
the PT recommended exercises or any								
range of motion exercises.			•					
Administrative staff indicated Client #2's		_						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMPI 05/03	LETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 B	ADDRESS, CITY, STATE, ZIP EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	wheelchair assessment could not be located from 12/30/10. No documentation could be located indicating Client #2 had an updated PT evaluation since the 6/16/2010 PT evaluation. 9-3-4(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLI	ETED
		15G559	B. WIN			05/03/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>		2901 BI	EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE			IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000257		IITORING & CHANGE					
		ogram plan must be by the qualified mental					
		ssional and revised as					
		ling, but not limited to					
	situations in which the client is failing to						
		dentified objectives after s have been made.					
	Based on intervi	ew and record review for	W0	00257	- The Service Coordinator will		05/31/2013
	1 of 2 sampled c	lients (#1), the Qualified			review all client goals for this		
	Intellectual Disa	bility Professional			home to assess if goals addre		
		monitor client #1's			issues including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of	a	
	` ` '	ermine if the client failed					
		s after three months.				,	
	to many progress	, with the contract of the con				of	
	Findings include				basic needs. If current		
	1 manigs merade	·•			programming is deemed, it will revised/modified with	lbe	
	Client #1's recor	d was reviewed on			IDT/guardian approval or the		
		AM. Client #1's 9/19/12			individual will be evaluated to	see	
		ort Plan (ISP) indicated			if they are developmentally		
	* *	e following objectives:			incapable of acquiring the skill and the goal will be discontinu		
	the enem had the	t following objectives.			by 5/31/13. Staff will be traine		
	"[Cliant #1] wi	Il continue to loom to			on implementing these goals to		
		Il continue to learn to			5/31/13. It will be documente	-	
	•	ame by October 31,			and return demonstration will		
	2012."				occur as needed.		
	"Whom aires -	ahaisa af 2 itama [aliant			To ensure future compliance,	The	
	_	choice of 2 items, [client			IDT will review audiological,	-	
	-	r the one she wants for 5			nutritional, health, developmer		
		sions by October 31,			and other assessments as the		
	2012."				are received, after any signific		
					change in client condition, or a least annually to compare ther		
		is called while she is			client goals and risk plans to		
	involved in an ac	ctivity, [client #1] will			ensure that all areas of need a	ıre	
	cease the activity	y of 0 of the last 0			being addressed. The Behavi	oral	
	sessions by Octo	ober 31, 2012."			Health Director or designee		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF11

Facility ID: 001073

If continuation sheet

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING	00	COM	TE SURVEY PLETED 03/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 B	ADDRESS, CITY, STATE, ZIP CO EVERLY DR IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	-"[Client #1] will touch a block with a number on it for 5 of the last 10 periods by October 31, 2012." -"When done eating, [client #1] will wipe her spot at the table after dinner for 12 of the last 24 sessions by October 31, 2012." -"Before medication is administered, [client #1] will respond correctly with 50% independence for 10 of the last 10 sessions by October 31, 2012." -"When asked to do so, [client #1] will wash her face with 90% independence for 10 of the last 12 sessions by October 31, 2012." Client #1's 9/19/12 ISP indicated no		monitor for completion is performing an audit on by 5/30/13. A random a client files will occur at it quarterly to ensure that client needs are being a by the team.	each file audit of east emerging	
	monthly summary reviews had been completed of the above mentioned objectives to determine if the client had met the objectives since the 9/19/12 ISP was implemented.				
	Interview with Service Coordinator (SC) #1/QIDP on 4/19/13 at 5:00 PM indicated she had taken over the group home as the new QIDP. SC #1 indicated she only had data for 3/13 to review. SC #1 did not provide any additional monitoring and/or monthly reviews of the client's objectives to determine if the client had failed to				

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Event ID: W6DF11

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G559	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMPI 05/03	LETED
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 BI	ADDRESS, CITY, STATE, ZIP (EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	make progress on the objectives after 3 months.				
	9-3-4(a)				

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		15G559	B. WIN			05/03/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46408		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000258	483.440(f)(1)(iv) PROGRAM MON The individual pro reviewed at least retardation profes necessary, includ situations in which considered for tra objectives. Based on intervie 1 of 2 sampled c Intellectual Disa (QIDP) failed to objectives to dete be considered for objectives. Findings include Client #1's record 4/17/13 at 11:41 Individual Support the client had the - "[Client #1] wi respond to her na 2012." -"When given a of #1] will reach for of the last 10 ses 2012." -When her name involved in an accord	distribution of the color of the color of 2 items, [client of 5 sions by October 31,	Wo	TAG 00258	The Service Coordinator will review all client goals for this home to assess if goals need address issues including, but I limited to, toilet training, perso hygiene, dental hygiene, self-feeding, bathing, dressing grooming, and communication basic needs. If current programming is ineffective it where the individual will be evaluated to if they are developmentally incapable of acquiring the skill and the goal will be discontinue by 5/31/13. Staff will be traine on implementing these goals to 5/31/13. It will be documented and return demonstration will occur as needed. To ensure future compliance, IDT will review audio logical, nutritional, health, developmentally occur as needed. To ensure future compliance, inches a service in client condition, or a least annually to compare the client goals and risk plans to ensure that all areas of need a being addressed. The Behavilland the Director or designate with the property or designate with the proper	not nal , of rill see ed d by f The ntal y ant at m to	05/31/2013
,	cease the activity	of 0 of the last 0			Health Director or designee wi	11	

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Event ID: W6DF11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SUPPLIER			2901 BE	EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sessions by Octo	ober 31, 2012."			monitor for completion by		
-"[Client #1] will touch a block with a number on it for 5 of the last 10 periods by October 31, 2012." -"When done eating, [client #1] will wipe				performing an audit on each fi by 5/30/13. A random audit of client files will occur at least quarterly to ensure that emergation needs are being address by the team.	f jing		
ı							
	•	ble after dinner for 12 of					
	the last 24 session	ons by October 31, 2012."					
	[client #1] will r	tion is administered, espond correctly with ace for 10 of the last 10 ober 31, 2012."					
	wash her face w	o do so, [client #1] will ith 90% independence for sessions by October 31,					
	monthly summa completed of the objectives to det	12 ISP indicated no ry reviews had been above mentioned ermine if the client had es since the 9/19/12 ISP d.					
	#1/QIDP on 4/19 she had taken over new QIDP. SC and data for 3/13 to a provide any additional scale.	dervice Coordinator (SC) 19/13 at 5:00 PM indicated for the group home as the 1 indicated she only had review. SC #1 did not 1 itional monitoring and/or 1 s of the client's objectives					

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G559	(X2) MULTIPLE CC A. BUILDING B. WING	00	_	
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 B	ADDRESS, CITY, STATE, ZIP EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	to determine if the client had been considered for training toward new objectives.				
	9-3-4(a)				

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Event ID: W6DF11

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO			COMPL	ETED
		15G559	B. WIN			05/03/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
4DC OF	NODELIMECT INDI	ANIA INC. THE			EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACT		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
W000264	483.440(f)(3)(iii) PROGRAM MON The committee sh make suggestions practices and pro- drug usage, phys rooms, application stimuli, control of protection of clien other areas that th need to be address Based on intervite facility failed to (Human Rights Consent for restrict to use of anesthe examination for (Client #2). Findings include On 4/18/13 at 1: for Client #2 ind diagnoses include to, mental retards congenital blinds disorder, and diagnoses Review of Cumulindicated Client draw for "preop" 11/12/12. The noindicated Client indicated Client in indicated Client	ITORING & CHANGE nould review, monitor and is to the facility about its grams as they relate to ical restraints, time-out in of painful or noxious inappropriate behavior, it rights and funds, and any the committee believes issed. We and record review, the ensure the facility's HRC Committee) had given inctive practices in regards is in for routine medical 1 of 3 sampled clients The control of the control o	W0	00264	The Service Coordinator will ensure that a desensitization p is developed and staff are trair on this plan by 5/31/13 for all clients requiring anesthesia for medical or dental appointment. This plan will be reviewed and approved by the Guardian, ID then HRC prior to the appointments. To ensure futur compliance, The Behavioral Health Director and Service Coordinator will obtain HRC are Guardian approval for all use of drug usage, physical restraints time-out rooms, application of painful or noxious stimuli, cont of inappropriate behavior, or protection of client rights and funds.	ned f.s. F.ee and of s,	05/31/2013

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CON	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	15G559	A. BUILDING B. WING	05/03/2013	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE		DDRESS, CITY, STATE, ZIP CODE EVERLY DR N 46408	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	On 4/19/13 at 12:40 PM, the Nurse Manager was interviewed and indicated the facility is not involved in guardianship consent for procedures requiring anesthetic and believed it was the hospital's responsibility to obtain guardian consent. The Nurse Manager indicated there is no facility policy or practice to require Human Rights Committee or guardian consent for anesthesia given during routine medical examinations to control behavior. The Nurse Manager indicated no further documentation was available to indicate Human Rights Committee consent was given for Client #2's gynecological examination under general anesthesia on 11/14/12.			

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G559	A. BUILDING B. WING		COMPLETED 05/03/2013		
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EVERLY DR		
	NORTHWEST INDI			,	IN 46408		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION DATE
W000318	483.460	LSC IDENTIFY ING INFORMATION)		TAG	BEI ICIENCI)		DATE
VV000510	HEALTH CARE S	SERVICES					
	The facility must ensure that specific health						
		uirements are met.					
		ation, interview and	W0	00318	The methodology by which		05/31/2013
	· ·	e facility failed to meet			nursing services are being delivered has been changed		
		Participation: Health			please refer to tags W331, W3	342.	
		r 2 of 2 sampled clients			W369	-,	
	` ′	for 2 additional clients					
	` ′	e facility's nursing					
		meet the health care					
		nts it served. The					
	facility's health care services failed to						
	assess, monitor a	and/or address clients'					
	health care needs	s, and failed to ensure					
	facility staff were	e trained to meet the					
	health needs of c	lients #2 and #3. The					
	facility's health c	eare services failed to					
	ensure all medica	ations were administered					
	without error for	client #2. The facility's					
	health care service	ces failed to ensure the					
	facility's practice	e in regard to times of					
	medication admir	nistration was reviewed					
	by client #1, #2 a	and #4's doctors.					
	Findings include	:					
	1. The facility's	Health Care Services					
	failed to ensure in	ts nursing services met					
		s of the client. The					
	•	Care Services failed to					
	•						
	-						
		· ·					
		to monitor and/or assess					
	failed to ensure in the nursing needs facility's Health (ensure its nursing plan in regard to to obtain clarifica	ts nursing services met s of the client. The Care Services failed to g services developed risk the client's health, failed ation for monitoring					

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	of correction identification number: 15G559	A. BUILDING B. WING	00	COMPLETED 05/03/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION
	a client's "diaper rash" and to ensure clients' doctors were aware the clients' Medication Administration Records did not specify a specific time on when the clients' medications were to be administered to ensure the doctor agreed with the facility's practice. The facility's Health Care Services failed to ensure its nursing services ensured ordered assessments were completed and a client's fall risk plan was updated for clients #1, #2, #3 and #4. Please see W331. 2. The facility's Health Care Services failed to ensure its nursing services ensured staff were trained in regard to aspiration pneumonia, peg tube feedings and/or provided competency based training to ensure all staff understood and knew how to adequately perform peg tube feedings and care for client #3. Please see W342. 3. The facility's Health care Services failed to ensure the facility administered all of client #2's medications during a medication pass. Please see W369. 9-3-6(a)			

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE : COMPL	
		15G559	A. BUII			05/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EVERLY DR		
	NORTHWEST INDI			GARY,	IN 46408		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		LSC IDENTIFTING INFORMATION)	+	TAG			DATE
W000331	483.460(c) NURSING SERVI The facility must pervices in accord Based on observation record review for (#1 and #2) and for and #4), the facility failed to meet the clients. The facility health, facility health, facility health, facility health, facility and to monitor diaper rash and doctors were away medication Administered to evith the facility's The facility's murensure ordered and accompleted acco	provide clients with nursing dance with their needs. ation, interview and r 2 of 2 sampled clients for 2 additional clients (#3 ity's nursing services e nursing needs of the lity's nursing services risk plan in regard to the iled to obtain monitoring residuals, and/or assess a client's at to ensure clients' are the clients' are the clients' are the clients' are the doctor agreed is practice. The single services failed to essessments were client's fall risk plan was	WO	00331	When a consumer is hospitalize the Community Services Nurse coordination with the Service Coordinator will develop plans address any changes in condition. A meeting will be head within 24 hours prior to or following discharge with the day program and others relevant to the client's care and documente am discussion and approval necessary. To prevent reoccurrence, this will be done all consumers returning home after hospitalization as a standard practice. The Medication Administration Schedule has been revised to reflect specific windows for administration. To ensure future compliance, The Behavioral Health Director or Community Services Operation Director will hold a weekly meeting to review changes in client status and ensure these meetings are scheduled or has been completed and document this discussion.	e in to eld ay to t sif e for dard che the	05/24/2013
	following:	-					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 05/03	LETED
	PROVIDER OR SUPPLIER			2901 BE	DDRESS, CITY, STATE, ZIP CODE EVERLY DR N 46408	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	#3] has a cold ar (sic) today due to up." The I/A "A indicated "It does and I did give her (saline) but it sti stuff (sic). I (day Safety Technicia come over and at the Health & Safeth edient on 3/8, called the nurse (sic). The 3/8/12 facility's nurse at -3/14/13 "The st #3] came in she looking well and staff notified the The health tech to temperature whire (103.5) and immore residential nurse giving [client #3 with applesauce 911 was called. #3's] temperature whire assessed [clings which was her abdomen where	ch was a high temp ediately called the . The health tech tried] crushed Tylenol (fever) but she would not take it. The nurse took [client e which was 103.8. The client #3] by checking her (sic) clear and checking ich was soft. The EMT's dical Technicians) arrived					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN	G		05/03/2013
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE	
					EVERLY DR	
ARC OF	RC OF NORTHWEST INDIANA INC, THE			GARY,	IN 46408	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	ì ·	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG	hospital]."	LESC IDENTIFTING INFORMATION)		TAU		DATE
	nospitarj.					
	The facility's 3/1	14/13 I/A Report indicated				
	upon arrival to the day program, staff					
	noticed a "chang					
		es" with client #3.				
	condition/injuric	ss with elient #5.				
	The facility's 3/14/13 Investigation Fact Sheet Summary and Conclusion indicated "Allegation: Possible Neglect-Consumer was transported to Day Services and appeared to be lethargic. Res (residential)					
		at client was a little extra				
	•	y morning. Staff had to				
		ast 4 times during				
		morning staff got client				
		hop-client took morning				
	1 *	applesauce & took blood				
	pressure 106/62.					
		t ate about 3/4 of				
		had to keep waking client				
		fast. Staff reported that				
	they were told by	y the previous nurse that				
	client would hav	ve good days & bad days				
	and some days v	vould seem a little extra				
	tired. Med drive	er picked client up and				
	was told by staff	f that client did not eat all				
	of her breakfast.	Med driver stated, that				
	client had no not	ticeable behaviors.				
	During the past ?	3 days, Res staff				
	noted-Monday c	lient was alert & trying to				
	feed self. Tuesd	lay client was doing a lot				
	of sleeping and l	had to wake client up to				
	feed her. Wedne	esday client was feeding				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	COM	ie survey ipleted 03/2013
	PROVIDER OR SUPPLIER		STRI 290	EET ADDRESS, CITY, STATE, Z 11 BEVERLY DR RY, IN 46408	TP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	CROSS-REFERENCED TO	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	fed her dinner in lot of her dinner that client did not night. Nurse did calls/pages in the did seem a little morning of 3-14 the ordinary for was told by prev be expected with not notice any di client the mornin. A 3/14/13 witner driver indicated to the workshop driver indicated not eat much (per noticeable behave Health Technician client in. Responsible to the workshop driver indicated client in the workshop driver indicated with the client of 3/14/13. The windicated client when the client of 3/14/13. The windicated " This wasn't breathing report on it. The	ss statement with the van he transported client #3 on 3/14/13. The van				

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	OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY PLETED 03/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2901 BI	ADDRESS, CITY, STATE, ZIP CO EVERLY DR IN 46408	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
			CROSS-REFERENCED TO THE AIDEFICIENCY)	PPROPRIATE	
	indicated "Wed (Wednesday) evening [client #3] seem (sic) to have a pretty decent evening however, she was a little tired. Most of the evening she sat up & before bedtime she spoke 2 to 3 words. She was very tired on Thursday morning. Once staff brought her out of her room,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLE	
		15G559	B. WING	G		05/03/2	2013
NAME OF F	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
450.05	NODEL IMPORTANT				EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	N 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
		e extra tired. Staff gave					
		ther blood pressure. I					
		the reading exactly but I					
		was in the normal					
	~	ritness statement by staff					
	•	revious nurse had told					
		rould "be tired off and					
	on."						
	A 2/15/12	ss statement by the Nurse					
		•					
		ndicated she had been					
	1	2 on 3/14/13 indicating					
		having the shakes &					
	_	as going over to check					
		shortly after & said it was					
	I	rgic, unable to swallow					
	1 -	911. I told her to do a					
	physical assessm	G .					
		le before leaving to hosp					
		#2] later told me she					
	1	gs x (times) 2 & they were					
		nurse cell phone & did					
	not receive any o	ealls the last 12 hours."					
	Client #21s hose	ital records were reviewed					
	_	00 PM. Client #3's					
		ergency department)					
	notes indicated of						
	were the followi	e ER (emergency room)					
	were the followi	ng.					
	"-Fever						
	-Shortness of Br	eath					
		or purplish discoloration					
	-Cyanosis (blue	or purprish discoloration					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/03		
	PROVIDER OR SUPPLIER		р. үүл	STREET A	ddress, city, state, zip codi VERLY DR N 46408	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	because of fever is not known how have persisted a physical was consisted inclusive): "B/P (blood pression of the pressi	had "Mottled (patches of color) skin, cool The 3/14/13 ED note at is here with fever and clinically epsis. We'll get labs, lood cultures. We'll give fluids and look for ent) has infiltrate on right TI (Urinary Tract (diagnosis) sepsis eumonia, UTI." Client icated client #3 was asspital's Intensive					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE A. BUILDING B. WING	00	COI	TE SURVEY MPLETED 03/2013		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	pneumonia bilate note indicated cl pneumonia and a needed to be con note indicated a was ordered.	pasesdevelopment of erally" The consult ient #3 had bilateral aspiration pneumonia asidered. The consult swallowing evaluation						
	Study indicated (Modified Bariu completed on 8/2 recommendation	"Previous MBS m Swallow) was 22/12 with						
	#3 was not able directionsNect delayed cough a straw) Puree:Pl and delayed cough swallow)Record swallow to r/o (r	ar: Pharyngeal (slightly fter the swallow with a naryngeal: (intermittent gh after the mmend modified barium ule out) aspiration).						
	mouth)" Client #3's 3/19/ Language Pathol (Cookie) Swallo swallow evaluati (Bedside) Swallo which revealed of swallow-suspicio	logist) Modified Barium w indicated "Last ion was a Clinical ow Evaluation 3/18/13 coughing after the ous for possible						
	which revealed of swallow-suspicion aspiration. Last l	coughing after the						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	LDING	NSTRUCTION 00		SURVEY LETED 5/2013
	PROVIDER OR SUPPLIER		2901 BE	DDRESS, CITY, STATE, ZIP COI EVERLY DR N 46408	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
TAG	aspiration or lary revealed pharyng reportedly cleared dry swallow." The MBS indication inclusive): "Consistencies A ThinPharynged Silent laryngeal swallow." NectarPharynged due to patient's stresidue after the PureePharynge to patient sensing the swallow.	ringeal penetration but geal residue which patient and independently with via the MBS indicated client to follow commands. Ited the following (not all assessed: al: Delayed Swallow. Ite penetration during the Ite geal: Cough-Immediate ensing pharyngeal swallow. Itel Cough-Immediate due g pharyngeal residue after	TAG		KOPKIATE	DATE
	to patient sensing the swallow" indicated client # Dysphagia: Mod Secondary to:: (s Pharyngeal dysp Compensatory S Patient did not for compensatory techniquesRec Recommendation	al: Cough-Immediate due g pharyngeal residue after The 3/19/13 MBS #3 had "Pharyngeal erate Risk of Aspiration sic) Orally dysphagia, hagia, and Cognition wallowing Strategies: follow commands or commendations: Diet ins NPO: Yes, due to to use compensations				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	for safety. Speed	1.0					
	swallowing not recommended due to						
	l ^	y to follow commands for					
	_	tory techniques for					
	safety."						
		cian Progress Note					
		ent's condition is					
	guarded. Failed	cookie swallowPlan					
	1.For (sic) Peg (t	feeding tube)."					
	Client #3's 3/21/	13 Modified Barium					
	(cookie) Swallov	w impression indicated					
	"Impression: Ep	oisode of laryngeal					
	penetration seen	with thin liquid					
	_	ip cup. No aspiration					
	. ^	amination showed no					
		ation or aspiration. Stasis					
	in vallecula (chro	_					
	`	(oral part of the airway)					
	dysphagia) persi						
		ssessment/Plan:Keep					
		y mouth) for now. Patient					
		g. Speech therapist					
		Patient failed cookie					
	swallow. For PE						
	Swanow. 10111	23 willollow.					
	 Client #3's 3/22/	13 Gastroenterology					
		dicated a "Pre-procedure					
	1	-					
	Diagnoses 1. Dysphagia [787.20] 2.						
	Failure to thrive in adult [783.7]." Client #3's hospital records indicated nursing						
		ring for residuals while					
	the client was in	the nospital.					

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	OF CORRECTION OF CORRECTION 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	CON	TE SURVEY MPLETED 03/2013		
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	Client #3's 3/27/13 Discharge Summary indicated client #3 was on bolus tube feedings. Client #3's discharge diagnoses included, but were not limited to, Sepsis, Bilateral Pneumonia" The note indicated "Pt was started on IV antibiotics and IVF (intravenous infusion). She was very lethargic initially but soon became more with it. She however failed cookie swallow and had to get a peg tubeCXR (sic) (chest X-ray) done 22/ (sic) showed worsening pneumonia and pts (sic) was referred to LTAC (long term acute care) admission for continued IV antibiotics. Brother would not hear of that so her antibiotics was (sic) changed to po (by mouth) and py (unidentified) is going back to group home." Client #3's 3/28/13 Patient Demographics sheet indicated the client was discharged to group home on 3/28/13. The demographics sheet indicated client #3's Final Diagnoses also included, but were not limited to, Septicemia (serious life threatening infection), Cyanosis, Dysphagia, Adult Failure to Thrive and Dehydration. Client #3's hospital records indicated the client was admitted for Septicemia, Pneumonia and Acute Respiratory Failure in 12/20/11 through 1/3/12. During the 4/16/13 observation period between 5:10 PM and 7;30 PM, at the						

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559		LDING	NSTRUCTION 00	(X3) DATE COMPI 05/03	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	At 6:15 PM, staff bedroom to give the peg tube and bolus feeding. Sinto the peg tube The staff pulled stopped. Staff #1 amount of water tube. Staff #1 pedissolved medicated the flushed and pour little at a time, in then flushed the remainder, of the feeding. Client against around the with staff #1 on she was instructed halfway and stop cloudy liquid up indicated they diamounts. Staff #1 feed the client as syringe did not be color." Staff #1 tube opening was staff #1 stated "as smell or drainage nurse." Staff #1 to clean around to picked up a wash dresser and said	ent #3 sat in a wheelchair. If #1 took client #3 to her her her medication via then to do the client's taff #1 placed a syringe to check for residual. The syringe to 30 and then then used a small to flush client #3's pegoured client #3's ations into the syringe, red 2 cans of Jevity, a sto the syringe. Staff #1 peg tube, with the eason of 30 cc of water after the eason of 30 cc						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MUL A. BUILD B. WING		00	(X3) DATE : COMPL 05/03/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	(X5) COMPLETION DATE	
	4/17/13 at 11:41 Logs indicated the inclusive): -3/4/13 "[Client running. Robafe Push fluids had the large BM (bower 13/5/12 BP (block))	d was reviewed on AM. Client #3's Daily ne following (not all #3] coughing & nose en given @ (at) 5:48. to be fed by staff. Very I movement)." ed pressure) 100/68 P ing else documented on						
	documented on t	/72 P 63 Nothing else						
	coughing and sh We are still givin wake her up at le for breakfast." T indicate the nurs	/62 P 74 "She is still e sounds congestion (sic). ng her Sudafed, had to east four times this AM The daily log neglected to e was called in regard to ge in health status.						
	Administration I client #3 receive	3 to 3/31/13 Medication Record (MAR) indicated d Saline Mist 1 spray in nes a day for congestion.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLET	
		15G559	B. WIN	G		05/03/20	013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	N 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		MAR indicated client #3					
	had a PRN (as n						
		e (Sudafed) 30 milligrams					
		every 4 hours as needed					
		tion. Client #3's MAR					
	also indicated th	e client had a PRN order					
	for Robitussin co	ough syrup 2 teaspoonfuls					
	every 4 hours PI	RN for chest congestion					
	or cough. Client	t #3's 3/13 MAR					
	indicated the clie	ent received the					
	following:						
	_						
	-3/4/13 Robituss	in cough syrup at supper					
		cough. The back of the					
		PRN is documented with					
	Reason & Resul						
		f the Robitussin was only					
	documented onc	•					
	documented one	C 011 37-47 13.					
	-3/6/13 Sudafed	at bedtime for nasal					
	congestion.	at ocatime for masur					
	congestion.						
	-3/7/13 Sudafed	in the morning (nasal					
		unch and bedtime					
		e lunch dose was not					
		the back of the MAR.					
	documented on t	HE DACK OF THE WAK.					
	2/9/12 Sudafad	in the marning for					
	-3/8/13 Sudafed in the morning for						
	coughing						
	2/0/12 D -1-:	in in the mamine for					
	-3/9/13 Robitussin in the morning for						
	cough.						
	2/0/12 5 1 5 1	11 12 0					
	-3/9/13 Sudafed	at supper and bedtime for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	l l	SURVEY LETED 5/2013	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP COD EVERLY DR N 46408	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	~	back of the MAR rse was called at 4:00 PM 2 tablets.					
	-3/10/13 Sudafection and bedtime for	d in the morning, lunch congestion.					
	bedtime for cong MAR indicated s	d in the morning and at gestion. The back of the staff did not document the t for the morning dose.					
	-3/12/13 Sudafe bedtime for cong	d in the morning and at gestion.					
	-3/14/13 Sudafed congestion.	d in the morning for					
	indicated client # Jevity 1.2 daily. give 2 cans @ 12 give 2 cans at 6p indicated "Flush (milliliters) of w (hours). Client # physician's order nurse did not cla regarding whether be checked/meas	peg tube (with) 300 ml ater q (every) 6 hrs #3's record and/or indicated the facility's rify/obtain an order er or not residuals should sured prior to feedings.					
		ulative Medical Record e notes) indicated the ll inclusive):					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559			LDING	NSTRUCTION 00	COMI	E SURVEY PLETED 3/2013		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	evaluated for Ho							
	-2/21/12 Client #3 was accepted in to Hospice program.							
		e Swallow not done due er harness. Will be						
	-8/22/12 "Cookie Swallow test completed. Pt has no instance of Penetration or Aspiration. Complete report to follow."							
	evaluation The	Ears, Nose Throat) doctor recommended se Saline Mist spray.						
		#3 went to her family 3's doctor indicated client clear.						
	[Client #3] temp W/C (wheelchair shaking. Very le Lungs clear bilat non-tender Bowe up by [name of co	el sounds present. Picked company] ambulance. name of hospital] ER						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G559	B. WING	G		05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY, I	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ed to [name of hospital]					
	for observation &	& treatment."					
	Client #3's Cum	ulative Medical record					
	failed to indicate	the facility nurse					
	assessed and/or of	documented her					
	assessment of cli	ient #3 on 3/8/13 when					
	the client was ha	ving difficulty breathing.					
		Record and/or client #3's					
	record failed to i	ndicate the facility staff					
	informed the nur	-					
	mentioned PRN	usage with the client					
		Nasal Spray 4 times a					
		y's nursing services failed					
	-	t #3 and/or assess the					
		when the daily log was					
		assess the client on					
	· · · · · · · · · · · · · · · · · · ·	f called the nurse about					
		estion. The facility failed					
	_						
	1	m was in place which					
		ity monitored PRN usage					
		are assessments of clients'					
	health as needed						
	01: 1//01 0/46/	10 M 1' 1 D '					
		12 Medical Review					
		ated client #3 was					
	_	12/21/11 for Pneumonia.					
		ndicated "2 attempts @					
	cookie swallow	8/2 and 8/14 (2012)."					
		2 Quarterly Nursing					
		cated client #3 was a					
		Client #3's record did not					
	indicate when cl	ient #3 stopped receiving					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN			05/03/2013
NAME OF I	DROVIDED OD GUDDI IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			2901 BE	EVERLY DR	
	NORTHWEST INDI			GARY,	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION CONTROL OF A CHICAN SHOULD BE A CHICA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	Hospice services	5.				
		11 typed letter from the				
	client's neurolog	ist indicated "The above				
	patient (client #3	s) suffers from Down's				
	Syndrome, autisi	m, mental retardation and				
	confusion which	are all contributing				
	factors for the di	agnosis of Dementia"				
	Client #3's undat	ted Caring For A J-tube				
	And When To C	all Your Nurse and/or				
	911 sheet indicat	ted "[Name of another				
		his group home] has a				
		ube) which is a procedure				
		all opening through the				
		to the small intestines1.				
		es needed: medications,				
		Occ (cubic centimeter)				
		sher, syringe with bottle,				
		al precaution (wash hands				
		• `				
		each task and water				
		ek the skin around the site				
	_	etion. These may include:				
	-Site is more ten	•				
	-Increased redne					
	T -	green in color or foul				
	smelling odor					
	-Excessive leaka	ge around the tube. **If				
	staff notices any	of the above signs of				
	infection contact	your nurse immediately.				
	**Make sure tha	t you keep the skin				
	around the tube	clean and dry. Clean the				
		site with plain water**If				
		lient] J-tube is pulled out				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G559	B. WIN			05/03/2013
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE	
450.05	NORTH WATERT IND				EVERLY DR	
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		EDIATELY. **If J-tube				
		d or clogged and staff				
		t call your nurse and the				
	nurse will give s					
		At the top of the undated				
		, a hand written statement				
		Instructions for Peg & J				
	tube feedings."					
	A :	and Completing				
	An instruction sl					
		Feedings with J-Tube or				
	_	ted "2. Checking for				
		J-tube or peg tube staff				
	_	e the stethoscope on the				
		bove the tubing, remove				
		bing and insert the				
	' '	tubing use the bulb and				
	1	into the tubing. Staff				
		ing sound which will let				
	l -	bing is in the correct				
	_	tructions sheet indicated				
	*	e to flush the tube with				
		p water before all				
		cations to ensure the peg				
		gged. The instruction				
		ted crushed pills were to				
		5cc of warm tap water				
		ith 15cc of warm tap				
	water. The instr					
		g tube was to be flushed				
		rm tap water after each				
		ove mentioned undated				
		s were located in a folder				
	in client #3's bed	lroom for staff to refer to.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUII	LDING	00	COMPL	
		15G559	B. WIN			05/03/	۷۱۱۵
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			EVERLY DR IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	Client #3's 8/16/ Plan (ISP) indicated the diagnosis of and/or record inconursing services care/risk plan for and the client's develop a risk plan spiration/Dysphethe facility would prevent aspiration tube/feedings. Condicated the fact failed to include tube which was sereflected the client's order water ordered), he checked/monitor indicated the fact failed to develop regard to how factor placement of	12 Individual Support ated the facility's nursing of indicate client #3 had Dementia. The ISP dicated the facility's failed to develop a rethe client's Dementia ecline in health. Client ated the facility failed to an for the client's nagia which included how demonitor the client to		TAG	DEFICIENCY)	IATE	DATE
	unblock a clogge	•					
		ne cards were reviewed on					
		PM. The facility's time I Shifts Worked by					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPI 05/03	LETED
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE EVERLY DR N 46408	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	had worked at th #3 returned to th tube on 3/28/13. The facility's ins	e group home since client e group home with a peg ervice/training records					
	The facility's Ind Training Report nurse conducted with the staff at the hours on "Feeding forms indicated I	n 4/16/13 at 11:47 AM. lividual Training/Group indicated the facility's an inservice on 3/28/13, the group home, for 2 ag Tube." The inservice LPN #1 conducted the					
	Training Reports and #9 had not b client #3's feedin Staff #9's 3/28/1.	cility's Individual indicated staff #7, #8 een trained in regard to g tubes/health needs. Individual Report indicated "[Client					
	water for meds 6 up 30 (degrees), (sic) dressing eventub (sic) out." T	g (regular) food, 5cc 0 water (sic) Must stay Turn (sic) 2 hr., Change ery night. Call 911 if pull the form indicated "Were					
	The 3/28/13 form documented "No The form was sign supervisor. The	vided effective? No." n indicated staff #10 t comfortable doing it." gned by the staff's form failed to indicate ovided additional training					
	treatment/proced ability. Review of	d/or perform the medical ure to the best of her of the 3/28/13 staff ndicated facility staff had					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	N 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	been told to diss						
	medications in 5	cc of water versus the					
	15cc of water as	indicated by the undated					
	instruction sheet	S.					
	_	ervice/training record					
	1	rvice program staff were					
	_	to client #3's feeding					
	tube on 4/8/13 fo	or 20 minutes by LPN #1.					
	The 3/28/13 and	4/8/13 training reports					
	neglected to indi	cate the nursing services					
	conducted comp	etency based training					
	(monitored/chec	ked off staff) to ensure					
	each staff unders	stood how to care for					
	client #3's peg tu	ibe and/or do peg tube					
	feedings. The fa	cility's facility's training					
	reports also indic	cated nursing services did					
	not ensure facilit	ty staff were trained in					
	regards to aspira	tion/aspiration					
	pneumonia.						
	Interview with s	taff #1 on 4/16/13 at 8:20					
	AM and at 5:55	PM indicated client #3					
	had not been fee	ling well for 2 weeks					
	prior to hospitali	zation. Staff #1					
	indicated client #	#2 had pneumonia first					
		3 got the pneumonia.					
		d client #3 had a peg tube					
		not do well on a cookie					
		aff #1 indicated facility					
		in regard to client #3's					
	peg tube feeding	-					
	1 -6	,					
	Interview with s	taff #6 on 4/16/13 at 3:50					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		OO	COM	TE SURVEY MPLETED
		15G559	B. WING			- 05/0	03/2013
	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP C VERLY DR N 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	trained in regard tube prior to the service program, service staff had since the placem #6 indicated they risk plans from to Interview with the on 4/17/13 at 2:0 not sure if staff versiduals. The N	ne Nurse Manager (NM) 00 PM indicated she was vere monitoring for IM stated "I have not					
	what staff should feeding, the NM Interview with the and the Director (DHCS), LPN #	home." When asked do during a tube stated "I don't know." The Nurse Manager (NM) of Health Care Services 1, SC #1 and the Program					
	indicated client # in the past. The was on Hospice had since been re Services. LPN # last hospitalized Pneumonia and r home on antibion client #3's brothe client #3 to get th indicated client # after the client fa	on 4/17/13 at 3:50 PM #3 had been on Hospice NM indicated client #3 for Failure to Thrive, but emoved from Hospice #1 indicated client #3 was for Aspiration returned to the group rics. The NM indicated er/guardian did not want the feeding tube. LPN #1 #3 received a Peg tube wiled a cookie swallow I not know if the client					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G559	A. BUII		00	COMPLETED 05/03/2013	
		199999	B. WIN			03/03/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			EVERLY DR IN 46408		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		oneumonia/aspiration.					
		cility staff should be					
	_	esiduals, LPN #1 stated					
		stated the residual would					
	be "cream color"	when checking the					
	residuals and the	client still had food in					
	her stomach. LP	N #1 indicated facility					
	staff should repor	rt residuals over 60 ml.					
	LPN #1 and the I	DHCS stated using a					
	wash cloth to cle	an the opening of the peg					
	tube would be " l	harsh." LPN #1 indicated					
	the facility staff	received a memo to					
	change the gauze	dressing daily. When					
	asked when facil	ity staff first notified					
	LPN #1 client #3	did not feel well, LPN					
	#1 stated "Not su	ire." The DHCS, NM					
		cated facility staff should					
		e nurse of the PRNs					
	client #3 received	d. LPN #1 and the NM					
	indicated facility	staff and the day					
		d been trained in regard					
	1 0	tube. When asked if					
	1 0	conducted competency					
		e staff understood and/or					
	_	rectly, LPN #1 indicated					
		ning had been conducted					
		y. LPN #1 indicated no					
		ning had been done with					
		the group home and/or					
		hen asked if staff had					
		egard to aspiration					
		#1 stated "No." LPN #1					
	*	delines/instructions in					
		how to administer					
	prace in regard to	now to auminister					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTII A. BUILDING B. WING		STRUCTION 00	(X3) DATE (COMPL 05/03 /	ETED
	PROVIDER OR SUPPLIER		ST. 29	01 BE	DDRESS, CITY, STATE, ZIP CODE VERLY DR N 46408	<u>I</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	specific in regards should clean the indicated client # plan for the Peg client #3 had a ri LPN #1 stated "I indicated client # in the past (2009 client #1's instruction what facility staff tube opening was the PC indicated with Dementia. indicated client # plan for Dement Interview with c 4/19/13 at 8:38 # was recently hos pneumonia and to tube for feeding, indicated he did have a peg tube, hospital it was not guardian stated "Not quality of lift improving. I am removed when since Client #3's guardian been hospital pneumonia. Client #3's guardian client # guardia	lient #3's guardian on AM indicated client #3 pitalized for aspiration the client received a peg Client #3's guardian not want client #3 to but was convinced by the the eeded. Client #3's I wasn't going to do it. The indicated client #3 lized in the past for tent #3's guardian					

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	COI	ATE SURVEY MPLETED 03/2013
	PROVIDER OR SUPPLIE		2901 BI	ADDRESS, CITY, STATE, ZII EVERLY DR IN 46408	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	#3 would surviv support with a b	e as the client was on life reathing tube.				
	4/19/13 at 1:35 know if client # on 3/8/13 due to breathing. The indicated an ass conducted and crecord. When a had been trained	he DHCS and LPN #1 on PM indicated they did not 3 was assessed by a nurse of the client's difficulty in DHCS and LPN #1 essment should have been documented in the client's sked if staff #6, #7 and #8 It in regard to the Peg tube, and she had no additional entation.				
	reports, internal Reports and/or i reviewed on 4/1 facility's report able incident rep	reportable incident Incident/Accident (I/A) nvestigations were 6/13 at 2:29 PM. The ports, I/A Reports and/or ndicated the following:				
	clients, [client # small scrape on not get her up b second staff can her up, put pillo indicated the sta	AM, "Went to check on [3] was on floor, has a her right knee. Could y myself. Waited until ne in at 6 AM. Covered w under head." The I/A aff called the nurse, left a phone and sent an e-mail.				
		PM, "Received a call ne staff stating that [client				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n her chair rocking					
		rmally does, and rocked					
	-	falling over sideways					
	-	nark on her forehead.					
		ient #3] back to her					
	sitting position a	and checked her for any					
	injuries. No app	parent injuries were found					
	other than the sn	nall red area on forehead.					
	Staff put pillows	on her sides to prevent					
	her from leaning	gover too far again. This					
	was an isolated i	ncident."					
	-The facility's 8/	16/12 I/A Report					
	indicated client	#3 fell "head first" to the					
	floor.						
	The facility's 8/2	21/12 follow-up report					
	indicated "The	ere were no additional					
	injuries incurred	from this incident, and					
		her forehead is healed.					
		ot fall back asleep after					
		e was not in a rocking					
		a regular arm chair.					
		tistic and rocks hard					
		whatever chair she is					
	seated in."	whatever chair SHT 18					
	scatcu III.						
	During the 1/16	13 observation period					
	_	A and 7:30 PM at the					
	group home, clie						
		n she arrived at the group					
	home. At 6:25 PM, staff #1 assisted						
		d and pivot to sit on the					
	couch. Client #3	3 was placed on the					

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	PROVIDER OR SUPPLIEI NORTHWEST IND		2901 BI	ADDRESS, CITY, STATE, ZIF EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	client upright. Simall stuffed an Client #3's upper forward. No state living room to reclient #3 had a pillow to each significant upon the read and upon until the stuffed to the floor. Client to her right not in a safe sitt PM, the surveyof #3 should be lead couch, staff #1 room and physicant straight. Staff #1 would lean to the During the 4/16 between 5:8 AM group home, cliewheelchair for renot ambulate and During the 4/16 between 2:40 Pt facility's owned remained in her	nobility. Client #3 did d/or use a gait belt. /13 observation period M and 4:20 PM, at the day program, client #3 wheelchair except to be #3 did not walk and/or				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE (A. BUILDING B. WING	00	COM	TE SURVEY SPLETED 03/2013	
	PROVIDER OR SUPPLIER		STREET 2901	T ADDRESS, CITY, STATE, ZII BEVERLY DR 7, IN 46408	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	4/17/13 at 11:41 3/13/13 physicia client's doctor or (Occupational T Therapy) eval (e chair assessment Syndrome, Dem Client #3's Cum notes and/or cha #3's OT/PT eval completed and/or Client #3's 3/7/1 Review indicate wheelchair for n Client #3's 8/16/ Assessment indicate wheelchair for an assessment indicate the use of a gait required "2 staff assessment indicate or more falls in the 8/16/12 assessm spent 2 or more wheelchair.	herapy/Physical valuation/ w/ (with) t Dx (diagnoses Down entia." ulative Medical Record rt did not indicate client uations had been or set up. 2 Quarterly Nursing d client #3 utilized a				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL 05/03/	ETED
	PROVIDER OR SUPPLIEI NORTHWEST IND		2901 BE	ADDRESS, CITY, STATE, Z EVERLY DR IN 46408	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	Maintain health number of falls. Grand Mal seizu fall. Client also gait. Baseline: for long distance walking." The findicated "Staff #3], at all times, Staff need to redown whenever fast" Client #3's 8/12, risk plan indicate services failed to client #3's fall risk glan glan glan glan glan glan glan glan	eason for the plan: and safety by reducingClient has a history of ares, which could cause a walks with an unsteady Client uses a wheelchair e; gait belt while fall prevention plan need to monitor [client , when she is walking. mind [client #3] to slow she is walking to (sic) //12 ISP and/or 8/12 fall led the facility's nursing or review and/or update lisk plan as the client uses mobility as the client's iorated.				
	4/19/13 at 3:00 to walk and talk #1 stated client Administrative s'had been sick f thrive." Interview with St the DHCS, the Mused a wheelcha	Administrative staff #1 on PM stated client #3 "used "." Administrative staff #3 was "In decline." staff #1 stated client #3 For a long time. Failure to SC #1, the PC, LPN #1, NM indicated client #3 air for ambulation. SC #1 were trying "side by side				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPLI	
		15G559	A. BUILDIN B. WING	NG		05/03/2	2013
				TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				VERLY DR		
ARC OF	NORTHWEST IND		G	BARY, I	N 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		#3 had an order to see the	1.	AG	DEFICIENCE)		DATE
		er chart. The NM					
		I not know if the					
		d been scheduled as					
		did not indicate the					
		been scheduled. SC #1,					
		CS and the NM did not					
	· ·	nt #3 had a fall risk plan.					
		d client #3's fall risk plan					
		e revised as it indicates					
	the client walks and utilizes a gait belt.						
		Ü					
	3. The facility's	reportable incident					
	1	Incident/Accident Report					
	-	tions were reviewed on					
	4/16/13 at 2:29 I	PM. The facility's 3/6/13					
	I/A Report indic	ated "While changing					
	[client #3], staff	noticed a sore on [client					
	#3's] upper right	thigh, right where her					
	depend sits at."	The I/A indicated the					
	Health & Safety	Tech was informed of					
	the area. The I/A	A indicated antibiotic					
	_	plied to the area and staff					
	were instructed	to not let the elastic of					
	the client's depen	nd rub against the area.					
	_	13 observation periods					
		M and 8:45 AM and 5:10					
		at the group home, client					
		chair for mobility. Client					
	#3 remained the	5 5					
		the wheelchair except					
	_	to 7:30 PM observation					
	period when the	client was placed on the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	COM	TE SURVEY MPLETED 03/2013
	PROVIDER OR SUPPLIEI NORTHWEST IND		STREET ADDRESS, CITY, STATE, ZIP CODI 2901 BEVERLY DR GARY, IN 46408		ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	4/17/13 at 11:41 Medication Adr (MAR) indicate Desitin Powder directed by the r referral to the pl The 3/13 MAR to be applied in supper and at be indicated staff a rash on client #3 following dates: -3/4/13 bedtime -3/5/13 morning bedtime -3/10/13 morning bedtime -3/11/13 morning bedtime -3/12/13 morning	and at bedtime and a support and at bedtime and at bedtime				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	2/21/12 at marr	ning lunch gunner and					
	bedtime.	ning, lunch, supper and					
	bedume.						
	Client #3's 4/2013 MAR indicated						
		applied daily since					
		3 3 to 4 times a day.					
	./1/15 10 4/10/1.	5 5 to 1 times a day.					
	Client #3's Daily	y logs from 3/4/13 to					
	l	the facility staff did not					
		ing in regard to the					
	1	or skin breakdown when					
		laily logs to the nurse.					
	l rer war amig and a	10Bs to the horse.					
	Client #3's Cum	ulative Medical records					
		ted client #3 saw her					
		ctor on 4/8/13. The					
		not indicate the facility					
		aware of any skin issues					
		f the desitin PRN on a					
	more regular bas						
		es also did not indicate					
		made the nurse aware of					
	1	elient's buttocks and/or					
		ssess the rash as there					
		ntation of the PRN usage					
	and/or rash.						
	Client #3's 8/16/	12 General Risk Factors					
		cated in the area of					
		ement, indicated client #3					
	•	hours a day in her					
	_	e risk assessment					
		#3 had a repositioning					
ı	muicaicu chelli	ms had a repositioning					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G559	B. WIN	G		05/03/	2013
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			2901 BE	EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	N 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	schedule.						
		44.700 ! 1! 1.1					
		12 ISP indicated the					
	client did not have a risk plan for skin						
		ncluded repositioning.					
	Client #3's ISP of	lid not indicate how					
	client #3 was to	be repositioned.					
	Internity 24 C	C #1 A. NIM 1 d					
		C #1, the NM and the					
	DHCS on 4/17/13 at 3:50 PM indicated						
	client #3 should be repositioned every 2						
		as not aware if client #3					
	had a skin integr	rity protocol/risk plan in					
	place.						
		DNI //1 // // // // // // // // // // // //					
		PN #1 on 4/19/13 at					
		ed client #3 was to be					
	-	ry 2 hours. LPN #1					
	indicated she wa	s not aware staff was					
	applying Desitin	to client #3's bottom.					
	LPN #1 indicate	d she had not seen client					
	#3's rash. LPN #	#1 indicated she was not					
	sure client #1 ha	d a risk plan in place for					
		PN #1 indicated the					
		C were to develop the					
		#1 indicated she did not					
	have access to the						
	nave access to th	ie risk pians.					
	4. During the 4/	16/13 observation period					
	_	M and 8:45 AM, at the					
		ents #1, #2 and #4					
	-						
	received morning medications at the 7 AM medication pass.						
		pass. ed medications for					
	Cheni #2 receive	ed medications for					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIP A. BUILDING B. WING	00	(X3) DATE S COMPL 05/03/	ETED
	PROVIDER OR SUPPLIER		STR 290	DRESS, CITY, STATE, ZIP CODE ERLY DR 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	supplements, however, and etc. Client # for allergies and					
	on 4/16/13 at 8:4 facility did not d when client #1, # were to be admin	#1, #2, #4's 4/13 MARs 15 AM indicated the esignate a specific time #2 and #4's medications nistered as the MARS Iorning, Lunch, Supper				
		d medication schedule 4/15/13 at 6:25 PM. er indicated the				
	administered bet AM and 11:59 A Lunch medication between 12 noon Supper medication administered bet PM bedtime (HS) medication administered bet PM.	ons could be administered and 2:00 PM				
	administered in					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 03/2013		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	7:00 AM and 7: BID (Two times in the evening TID (Three times bedtime Every 8 hours s. 6:00 AM, 2:00 DQID (Four times supper and bedt Client #2's record 4/18/13 at 1:00 physician's order Record and/or reclient's physician facility's medical practice. Client #1's record 4/18/13 at 4:00 physician's order Record and/or reclients' physician's order Record and/or reclients' physician's order Record and/or reclients' physician's physician's order Record and/or reclients' physician's phy	should be administered at 00 PM s a day) AM and at supper es a day) AM, lunch and hould be administered at PM and 10:00 PM s a day) AM, lunch,						
	4/16/13 at 1:00 not aware of the memo/typed no DHCS indicated	he NM and DHCS on PM indicated they were above mentioned te. The NM and the I they were not aware no es were on client #1, #2,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G559	B. WIN	G		05/03/	2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	N 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		AM, lunch PM and HS.					
		cated the MARs should					
	have specific times. The NM indicated						
		l #4's doctor was not					
		ns were not given at					
	`	acility's medication					
	administration p	ractice).					
	5 On 4/16/13 at	t 11:49 AM, the facility					
		of Developmental					
	`	ices) reports were					
		/16/12 to 4/1/13. A					
		bmitted 3/6/13 indicated					
	_	sessed by the nurse due					
		excess coughing. The					
	1	Client #2 was congested					
		the emergency room. The					
		Client #2 was admitted to					
		low oxygen levels and					
	was receiving ox						
	was receiving ox	rygen.					
	On 4/18/13 at 1:	00 PM, a record review					
	for Client #2 ind	icated client #2's					
	diagnoses includ	led, but were not limited					
	to, mental retard	ation, Down Syndrome,					
	congenital blinds	ness in right eye, seizure					
	disorder, and dia	• •					
		Support Plan (ISP) for					
		9/26/12 indicated risk					
	plans for the foll	owing: seizure disorder,					
	gastrointestinal b	pleeding and decreased					
	endurance due to	iron deficiency,					
	diabetes, hyper of	or hypo glycemic reaction,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN	IG		05/03/2013
NAME OF B	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIER			2901 BE	EVERLY DR	
	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	_	tion related to fracture,				
	heart attack or st					
	hyperlipidemia,	hypertension, and				
	constipation.					
	-A General Risk Factors Assessment					
		dicated in the Dysphagia				
		2 "is on or has been on				
		nd/or fluid textures in past				
		•				
		ion control, chopped." In				
		ection of the assessment it				
		any item is checked,				
		Assessment for Choking				
		Eat By Mouth' and				
	'Assessment of F	Pneumonia Risk' and				
	forward to Outre	each." No further				
	documentation of	f choking or pneumonia				
	risk assessments	could be located.				
	An Interdigainli	nary Team meeting				
	_					
	1	9/26/12 indicated no				
	_	lans for allergies and				
	choking.					
	-A choking risk	plan for Client #2 dated				
		ated Client #2 ate a				
	_	e risk plan indicated staff				
	_	e Client #2 to slow down				
		sit upright while				
		to bring her face closer to				
	plate while eatin	_				
	_	-				
		rould know the symptoms				
		on and know the signs of				
	dysphasia. The	plan indicated dysphasia				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		15G559	B. WIN			05/03/	2013
(F. 6F. F					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		2901 BE	EVERLY DR		
	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		piration pneumonia. The					
		ed staff "should call the					
	_	[‡] 2's] coughing/choking					
	appears to be worsening." The plan						
	indicated staff should document episodes						
	_	e daily narrative and an					
		hould be filled out if staff					
	needed to physic	eally assist Client #2					
	during a coughir	ng or choking episode.					
	On 4/18/13 at 2:	29 PM, Client #2's					
	discharge paperv	work from her hospital					
	admission betwe	en 3/5/13 and 3/19/13					
	was reviewed. T	he hospital discharge					
	paperwork indic	ated Client #2 "presents					
	with complaint of	of cough and congestion					
	onset one day pr	ior to admission.					
	Caregiver per re	port also states that					
		een wanting to eat for the					
	_	[prior to admission].					
		ever. Caregiver states the					
	1	bal, but has been whining					
	_	ays. States patient is					
	usually a very go	•					
		to not want to eat. States					
		became worse today."					
	l ^	aperwork indicated Client					
		to the hospital with					
		ess, aspiration pneumonia,					
		ck liver (Ischemic					
		,					
	•	sed blood supply to					
	liver).						
	-A hospital swal	low evaluation dated					

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPI 05/03	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
	in diet from chor	d a recommended change oped to puree diet with ar thickened liquids, and tes only.						
	service program Staff #4 indicate any choking, asp risk plans for Cli indicated Client day service prog cataracts, fall ris impaired circulat Staff #4 indicate communication t and the day servi indicated the nur any client health indicated she wa was admitted to diet change to pu the facility would	#2 had risk plans in the ram for iron deficiency, k, constipation, and tion related to fracture. d there was no direct between the group home fice staff. Staff #4 se would inform them of concerns. Staff #4 s unaware why Client #2 the hospital and had a tree. Staff #4 indicated d not inform her of the						
	#4 indicated she (Health Insuranc Accountability A her of Client #2's During an interv PM, the Nurse M policy was staff needed) medicat	2's hospital stay. Staff was told it was a HIPAA e Portability and act) violation to inform s hospital information. iew on 4/18/13 at 4:30 Manager indicated facility could give PRN (given as ion without checking at notifying nursing staff.						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		00				
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	LPN #1 indicated staff had not been trained on identifying the signs and symptoms of aspiration pneumonia when she returned from the hospital. The Nurse Manager indicated no additional care plan for aspiration pneumonia had been developed when Client #2 returned from the hospital. 9-3-6(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DDIC	00	COMPL	ETED
		15G559	A. BUILDING B. WING 05/03/2013			2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
ADC 05 I	NODTI IMEGT INDI	IANIA INIC. THE			EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000342	483.460(c)(5)(iii)						
	NURSING SERV						
		must include implementing					
		ers of the interdisciplinary					
		e protective and preventive					
		that include, but are not direct care staff in					
		nd symptoms of illness or					
		aid for accidents or illness,					
		equired to meet the health					
	needs of the clien	= -					
	Based on observ	ation, interview and	W0	00342	Client # 3 has been discharge	d	05/31/2013
	record review for	r 1 additional client (#3),			from the program. Since		
		sing services failed to			discharge her peg tube has be	en	
	-	e trained in regard to			discontinued. If she is able to		
		_			return to the program or other		
		nonia, peg tube feedings			consumers require a peg tube		
	-	competency based			other medical devices, a risk p providing instruction for care w		
	training to ensure	e all staff understood and			be developed and the Commu		
	knew how to ade	equately perform peg tube			Services Nurse will train and	····cy	
	feedings and care	e.			monitor staff on the peg tube f	or	
	J				care, cleaning, and feeding da		
	Findings include				until such time staff demonstra	-	
	r manigs include	•			competency with the peg tube		
					other medical devices. Trainir	•	
		ortable incident reports,			will involve modeling and retur	'n	
	internal Incident	/Accident (I/A) Reports			demonstrations will be	_	
	and/or investigat	ions were reviewed on			documented. Nurse monitorin	-	
	4/16/13 at 2:29 F	PM. The facility's			will decrease according to staf competency and monthly	1	
	reportable incide	ent reports, I/A reports			thereafter. Staff will also be		
	•	tions indicated the			trained on detecting change in		
	following:	none maiorior mo			physical conditions such as		
	ionowing.				aspiration pneumonia, and wh	en	
	2/0/42	D. F. H.G			to call the Nurse.		
		PM, "Staff noticed [client					
	#3] has a cold an	nd is breathing different			To ensure future compliance,		
	(sic) today due to her nose being stopped				Area Manager will refer all nev	V	
	up." The I/A "A	ction Taken" section			staff at the home to the	ho	
	-	s seem that she has a cold			Community Services Nurse, w will ensure staff are trained on		
	marcaica it uoc	5 500m that she has a colu			will crisure stail are trained on	all	

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G559	B. WIN			05/03/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NODTUMEST INDI	ANA INC. THE			EVERLY DR		
	NORTHWEST INDI				IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		r meds of nasal spray	+	TAG	medical needs for the home.		DATE
	_	Il seems that her nose is			Documentation will be forward	ed	
	` ′	y service Health & (and)			to the Area Manager to assure	;	
	` ´ ´ ` •		completion.				
	come over and a	n) call (sic) the nurse to					
	come over and a	ssess.					
	2/14/12 "The et	off natical when Caliant					
		aff noticed when [client was shaking and not					
	_	looking right. the (sic)					
		health tech (technician).					
		` ,					
	The health tech t	= =					
	_	ch was a high temp					
	` ′	ediately called the The health tech tried					
		crushed Tylenol (fever)					
		but she would not take it.					
		The nurse took [client					
	- 1	e which was 103.8. The					
	_	elient #3] by checking her					
		(sic) clear and checking					
		ich was soft. The EMT's					
		dical Technicians) arrived					
	and took [client	#3] to [name of					
	hospital]."						
	Ol: //21 1 :	4-11					
	•	tal records were reviewed					
		00 PM. Client #3's					
	,	ergency department)					
		lient #3 chief complaints					
	` •	gency room) were the					
	following:						
	"-Fever	d					
	-Shortness of Bro	eatn					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559			LDING	NSTRUCTION 00	(X3) DATE COMPI 05/03	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	of skin) -Blood infection because of fever is not known how have persisted a physical was c ED note indicate inclusive): "B/P (blood pres Temp(Src) 102.4 (Celsius) (Rectal 14SpO2 (room ED note indicate "Lethargic" and skin irregular in extremities" indicated "Patier hypotension and consistent with s lactic acid and b IV (intravenous) sourcePt (paties sidealso w/UT Infection)Dx (secondary to pne #3's ED note ind admitted to the h Medical Care Un Client #3's 3/15/ Consult Note inc "Mild patchy pne	had "Mottled (patches of color) skin, cool The 3/14/13 ED note at is here with fever and clinically epsis. We'll get labs, lood cultures. We'll give fluids and look for ent) has infiltrate on right TI (Urinary Tract (diagnosis) sepsis eumonia, UTI." Client icated client #3 was asspital's Intensive						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		15G559	B. WIN	G		05/03/	2013
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	N 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		lateral hilar and perihilar					
	1 0	pasesdevelopment of					
	_	erally" The consult					
	note indicated cl	ient #3 had bilateral					
	_	aspiration pneumonia					
	needed to be cor	nsidered. The consult					
	note indicated a	swallowing evaluation					
	was ordered.						
	Client #3's 3/18/	13 Clinical Swallow					
		"Previous MBS					
		m Swallow) was					
	completed on 8/2	· · · · · · · · · · · · · · · · · · ·					
	recommendation						
		soft (gravy to meats) and					
	_	ne study indicated client					
	#3 was not able						
		ar: Pharyngeal (slightly					
		fter the swallow with a					
	/	naryngeal: (intermittent					
	and delayed cou	_					
		mmend modified barium					
	`	rule out) aspiration).					
	Recommend kee	p NPO (nothing by					
	mouth)"						
	Client #3's 3/19/	13 SLP (Speech					
		logist) Modified Barium					
	1	w indicated "Last					
	` ′	ion was a Clinical					
		ow Evaluation 3/18/13					
	, ,	coughing after the					
	swallow-suspicion						
	_	known Modified Barium					
	aspiration. Last i	MIOWII MIOUITICU DAITUIII					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		LDING	NSTRUCTION 00		ESURVEY LETED 3/2013	
	PROVIDER OR SUPPLIER		 2901 BE	DDRESS, CITY, STATE, ZIP COI EVERLY DR IN 46408	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
TAG	Swallow Study 8 aspiration or lary revealed pharyng reportedly cleared dry swallow." The MBS indication inclusive: "Consistencies A ThinPharynge a Silent laryngeal swallow. NectarPharynge due to patient's stresidue after the PureePharynge to patient sensing the swallow. SolidPharynge to patient sensing the swallow" indicated client for pharyngeal dysp Compensatory Stresidy Scompensatory Stresidy Stresidy Secondary to:: (stresidue) (stresidu	8/22/12 revealed no regeal penetration but geal residue which patient and independently with via the MBS indicated client to follow commands. Ited the following (not all assessed: al: Delayed Swallow. Penetration during the geal: Cough-Immediate ensing pharyngeal	TAG		ROPRIALE	DATE
	_	ommendations: Diet ns NPO: Yes, due to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G559	B. WIN			05/03/2013
NAME OF F	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST IND	IANA INC. THE			EVERLY DR IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	patient's inability	y to use compensations				
	for safety. Speed	ch Therapy for				
	swallowing not i	recommended due to				
	patient's inability	y to follow commands for				
	use of compensa	tory techniques for				
	safety."					
	. 2/20/12 51 .					
		cian Progress Note				
		ent's condition is				
	~	cookie swallowPlan 1.				
	For (sic) Peg (fe	eding tube)."				
	Client #3's 3/21/	13 Modified Barium				
	(cookie) Swallov	w impression indicated				
		oisode of laryngeal				
	penetration seen	with thin liquid				
	presented with s	ip cup. No aspiration				
	seen. Rest of ex	amination showed no				
	laryngeal penetra	ation or aspiration. Stasis				
	in vallecula (chr	onic severe				
		(oral part of the airway)				
	dysphagia) persi					
		ssessment/Plan:Keep				
		y mouth) for now. Patient				
		g. Speech therapist				
		Patient failed cookie				
	swallow. For PI	EG tomorrow."				
	Client 3's 3/27/1	3 Discharge Summary				
		#3 was on bolus tube				
	feedings. Client					
		led, but were not limited				
	•	eral Pneumonia"				
	, 1 ,					
	I		- 1			l

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G559	A. BUII	LDING	00	05/03/2	
		15G559	B. WIN			05/03/	2013
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE EVERLY DR		
ARC OF	NORTHWEST IND	DIANA INC, THE			IN 46408		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		/13 observation period					
		M and 7;30 PM, at the					
		ent #3 sat in a wheelchair.					
	1 · · · · · · · · · · · · · · · · · · ·	ff #1 took client #3 to her					
		e her her medication via					
		d then to do the client's					
		Staff #1 placed a syringe					
		e to check for residual. the syringe to 30 and then					
	_						
		1 then used a small r to flush client #3's peg					
		ooured client #3's					
	_	eations into the syringe,					
		ared 2 cans of Jevity, a					
	_	nto the syringe. Staff #1					
	-	e peg tube, with the					
		ie 300 cc of water after the					
		#3's peg tube opening had					
	1	the raw opening. Interview					
		4/16/13 at 6:15 PM stated					
		ted to only "pull up					
		p." The syringe had					
	1	to the 30 mark. Staff #1					
	1 , , ,	lid not measure residuals					
	1	#1 indicated they could					
		s long as the liquid in the					
		have "Jevity (liquid food)					
	1 -	indicated client #3's peg					
		as cleaned every morning.					
		'a little blood is ok. If					
		ge changes color, call					
	1	stated she used a "Q-tip"					
		the opening. Staff #1					
		sh cloth which was on the					
	1						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 03/2013
		15G559	B. WING			03/2013
	PROVIDER OR SUPPLIER		2901 E	address, city, state, zi BEVERLY DR , IN 46408	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE OFFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
		some staff used a wash tated the wash cloth was				
	4/17/13 at 11:41 Caring For A J-t Your Nurse and/ Name of another group home] has which is a proce- opening through the small intestir supplies needed: gloves, 30cc (cu pill crusher, syri- Universal precau and after each ta Check the skin a infection. These -Site is more ten -Increased redne -Drainage that is smelling odor -Excessive leaka staff notices any infection contact **Make sure tha around the tube of skin around the se [name of other c CALL 911 IMM becomes blocked	der and painful				

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O O D. WING			COMPLETED 05/03/2013	
		15G559	B. WIN	G		05/03/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			EVERLY DR IN 46408		
(X4) ID		FATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	nurse will give st	aff further					
		At the top of the undated					
		a hand written statement					
		Instructions for Peg & J					
	tube feedings."	٥					
	S						
	An instruction sh	neet for giving					
		Feedings with J-Tube or					
		red "2. Checking for					
	_	J-tube or peg tube staff					
	•	e the stethoscope on the					
	-	pove the tubing, remove					
		bing and insert the					
		ubing use the bulb and					
		into the tubing. Staff					
		ing sound which will let					
		oing is in the correct					
	-	ructions sheet indicated					
	_	e to flush the tube with					
	<u>-</u>	p water before all					
		cations to ensure the peg					
	-	gged. The instruction					
	_	ted crushed pills were to					
		5cc of warm tap water					
		ith 15cc of warm tap					
	water. The instru	_					
		tube was to be flushed					
		rm tap water after each					
		ove mentioned undated					
	_	s were located in a folder					
		room for staff to refer to.					
	in chent #3's bed	100111 101 Statt to refer to.					
	The feetile test						
	I -	e cards were reviewed on					
	4/1//13 at 2:00 P	M. The facility's time	\perp				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE : COMPL		
1111212111	or conditions	15G559		LDING		05/03/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST IND	ANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		l Shifts Worked by licated staff #7, #8 and #9					
	•	e group home since client					
		e group home with a peg					
	tube on 3/28/13.	e group nome with a peg					
	1400 011 3/20/13.						
	The facility's ins	ervice/training records					
	were reviewed o	n 4/16/13 at 11:47 AM.					
		lividual Training/Group					
		indicated the facility's					
		an inservice on 3/28/13,					
		the group home, for 2					
		ng Tube." The inservice					
		LPN #1 conducted the					
	_	cility's Individual					
		s indicated staff #7, #8					
		een trained in regard to					
		g tubes/health needs.					
	Staff #9's 3/28/1						
		Report indicated "[Client					
		g (regular) food, 5cc					
		0 water (sic) Must stay					
		Turn (sic) 2 hr., Change ery night. Call 911 if pull					
	` ′	he form indicated "Were					
	` ′	vided effective? No."					
		n indicated staff #10					
		ot comfortable doing it."					
		gned by the staff's					
	· ·	form failed to indicate					
	_	ovided additional training					
	-	d/or perform the medical					
		lure to the best of her					
		of the 3/28/13 staff					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G559	B. WIN			05/03/2	2013
NAME OF F	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE, ZIP CODE		
4DC OF	NODTI IMEGT IND	IANIA INIC. THE			EVERLY DR		
	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG		indicated facility staff had	+	TAG			DATE
	been told to diss	•					
		cc of water versus the					
	instruction sheet	indicated by the undated					
	instruction sheet	S.					
	The facility's in-	ervice/training record					
		rvice program staff were					
		to client #3's feeding					
		or 20 minutes by LPN #1.					
		4/8/13 training reports					
		cate the nursing services					
	~	etency based training					
	_						
	`	ked off staff) to ensure stood how to care for					
		ibe and/or do peg tube					
	_	cility's facility's training					
		cated nursing services did					
		ty staff were trained in					
	regards to aspira	tion/aspiration					
	pneumonia.						
	T.,4	N					
		ne Nurse Manager (NM)					
		of Health Care Services					
		1, SC #1 and the Program					
	,) on 4/17/13 at 3:50 PM					
		#3 received a peg tube					
	•	ed in 3/13. LPN #1					
		#3 was last hospitalized					
	_	neumonia and returned to					
		on antibiotics. LPN #1					
	and the NM indicated facility staff and the						
		ff had been trained in					
	regard to client #	[‡] 3's peg tube. When					

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
15G559		A. BUILDING B. WING	05/03/2013		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET . 2901 B	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) COMPLETION DATE	
	asked if nursing competency training understood and LPN #1 indicate had been conducted LPN #1 indicate had been done with a sked if staff had been asked if staff had been done with the staff had been done with the sked if ske	staff had conducted uning to ensure staff for fed the client correctly, ed competency training cted with staff #1 only. ed no competency training with the other staff in the dor day program. When d been trained in regard to monia, LPN #1 stated			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/03/2013		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		B. WING GS/03/2013 STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview and record review for 1 of 26 medications administered, the facility failed to administer a medication to client #2. Findings include: During the 4/16/13 observation period between 5:38 AM and 8:45 AM, at the group home, staff #2 administered client #2's morning medications. Staff #2 did not administer Docusate Sodium (stool softener) to client #2. Client #2's Medication Administration Record (MAR) was reconciled on 4/19/13 at 8:45 AM. The April 2013 MAR indicated client #3 was to receive Docusate Sodium 100 milligrams in the morning. Staff #2 did not administer the client's Docusate Sodium. Client #2's record was reviewed on 4/19/13 at 3:58 PM. Client #2's 3/19/13 physician's order indicated client #2 was to receive Docusate Sodium 100 milligrams twice daily in the morning and in the evening.	W000369	The Community Services Nurwill train all DSPs on proper medication administration in accordance Core A of Living in the Community and Physician order by 5/31/13. Training will involve modeling, and return demonstrations and will be documented. The Community Services Nurse will monitor eastaff performing a medication pass per week for four weeks, monthly for two months and periodically thereafter. In addition the Nursing Department will review the Maweekly, once proficiency has been established reviews will occur biweekly then monthly thereafter.	n 's / ach		

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PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 15G559	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM 05/	TE SURVEY MPLETED 03/2013		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Interview with staff #2 on 4/16/13 at 8:45 AM indicated client #3 did not receive the ordered Docusate Sodium at the morning medication pass. Staff #2 stated the Docusate Sodium "was in with the night meds." 9-3-6(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			` ′	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED			
		15G559	B. WING	ì		05/	/03/2013
	PROVIDER OR SUPPLIER			2901 BE	ADDRESS, CITY, STATE, ZIP COD EVERLY DR IN 46408	Έ	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W000448	with evacuation of Based on record 2 of 2 sampled of 2 additional client facility failed to concerns/problem PM to 7:00 AM) Findings included The facility's fired 4/16/13 at 2:00 Indicated the followernight shift of dand #4: -4/23/12 "The client the difficult part wheelchairs throw leaving the client making sure they out." The report manager reviewed the report indicated the report indicated the report indicated the surface of the surf	investigate all problems Irills, including accidents. review and interview for lients (#1 and #2) and for ints (#3 and #4), the address ins with overnight (11:00 of fire drills. E. drills were reviewed on PM. The facility's fire ast year (4/12 to 4/13) lowing concerns with the rills for clients #1, #2, #3 ients responded well but was getting the ugh the doors & (and) its outside without a staff of are safe as I went & indicated the area manager indicated the area manager indicated the area manager	WOO	00448	Area Manager and Servic Coordinator will review or raised during fire drills and develop plans to modify the environment to address the concerns by 5/31/13. Stattrained on these modification and will show proficiency implementation by 5/30/1 Manager will observe a fill monthly until such time stolients are able to evacual building safely. Once profin evacuations is establismonitoring of fire drills with faded to quarterly. Recommendations will be to ensure the safety of all and staff during overnigh drills.	oncerns d will he hose ff will be tions in their 3, Area re drill taff and ate the officiency hed ll be e made	05/30/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559			LDING	NSTRUCTION 00	(X3) DATE COMPI 05/03			
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
	the wheelchairs. to open & hold to clients in the whole aving the client report indicated reviewed the report indicated reviewed the report indicated the report of the stay out would went to get the object of the above mention indicated the are report on 4/9/13. The above mention indicate any reconstructive actions. Interview with a 4/19/13 at 3:28 If double staffing, indicated there with a sleep Administrative seamer as out back staff #3 did not produce the staff and the s	B PM, "Difficult with tent #3] because 1 staff with client while the other ther clients." The report a manager reviewed the coned reports did not commendations and/or staken. dministrative staff #3 on PM stated "We went to Administrative staff #3 sed to be cameras in the postaff at night. taff #3 stated "We took in fall." Administrative crovide any additional and/or interviews in how essed the overnight shift						

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